

No. 2  
4-13-40  
5-17-39  
PI X23153

**MAR 25 1941**

Registration District No. 384

Primary Registration District No. 5535

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Howell  
 (b) City or town Howell, Mo.  
 (c) Name of hospital or institution: \_\_\_\_\_  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
50 Yrs (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Howell  
 (c) City or town Koshkonong R.F.D.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Jennings L Nicks  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Jan day 25  
 year 1941 hour 4 minute 15 P.M.

4. Sex M 5. Color or race Wh  
 6. (a) Single, widowed, married, divorced Widower  
 (b) Name of husband or wife Rena Putman  
 (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased June 1 1861  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

8. AGE: 79 Years 6 Months 25 Days  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Write Myocardial  
 Duration \_\_\_\_\_

9. Birthplace Wisconsin  
 (City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

10. Usual occupation Retired Farmer

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 12. Name Doak Nicks  
 13. Birthplace Wis  
 (City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

14. Maiden name Unknown  
 15. Birthplace Unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant Doak Nicks  
 (b) Address Koshkonong Mo

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 28 41  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation Philadelph Cem

While at work? \_\_\_\_\_ (Specify type of place)  
 (d) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director Geo. C. Cramer  
 (b) Address Phayer Mo

23. Signature John J. Green (M.D. or other) \_\_\_\_\_  
 Address Mt. View Mo Date signed \_\_\_\_\_

19. (a) 2-3-41 (Date received local registrar)  
 (b) Vida W. SIMONS (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

26  
0  
0

RECEIVED

District Health Officer No. 5,

District File Number. 34/343

Date Filed \_\_\_\_\_

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed \_\_\_\_\_

Licensed Embalmer No. 2852

P. O. Address. Thayer Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.