DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 17 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8516

Registration District No. 497 Primary Registration District No. 4543 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Webster

(b) City or town Seymour
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 6 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster 112

(c) City or town Seymour 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location) 0

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mary Ellen Nix

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Tom Nix

6. (c) Age of husband or wife if alive years

7. Birth date of deceased December (Month) 29 (Day) 1855 (Year)

8. AGE:

Years	Months	Days	If less than one day
85	1	3	hr. min.

9. Birthplace Christian C. (City, town, or county) Mo (State or foreign country)

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name Joseph Abbott
13. Birthplace (City, town, or county) Virginia (State or foreign country)

MOTHER
14. Maiden name Rebecca Adams
15. Birthplace (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant Mrs. Birdie Baty
(b) Address Seymour, Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Feb (Month) 3 (Day) 1941 (Year)
(c) Place: burial or cremation Pedalo cemetry

18. (a) Signature of funeral director Denver Roller
(b) Address Ava, Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2
year 1941 hour 4 minute 15 A M.

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

	Duration
Immediate cause of death	
Due to	
Due to Natural Cause	
Other conditions Left side paralysed for 4 years (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. E. G. Beers Coroner (M. D. or other)
Address Seymour Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
File Number 341-357
Date Filed MAR 4 1941

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 .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed .....

Licensed Embalmer No. .....

P. O. Address .....

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

If this body is not embalmed, above space should be left blank.

2B
-40
22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8576

Registration District No. 897 Primary Registration District No. 4843 Registrar's No.

1. PLACE OF DEATH:
(a) County Webster
(b) City or town Seymour
(If outside city or town limits, write "RURAL" and name of township)
(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 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(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 Mary Ellen Nix
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 5-3-41 (Date received local registrar) (b) R E McMahan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

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

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature E. G. Beers (M. D. or other) Coroner
Address Seymour Mo. Date signed

SUPPLEMENTARY

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8516

Registration District No. 897 — Primary Registration District No. 4545 — Registrar's No.

1. PLACE OF DEATH:
(a) County: Webster
(b) City or town: Seymour
(If outside city or town limits, write "RURAL" and name of township)
(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 ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Mary Ellen Nix
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: wd
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years 85 — Months 1 — Days 3 — If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)
16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2 year 1941 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....;
that I last saw h..... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Natural Causes	
Due to:	
Due to: Cerebral hemorrhage	
Other conditions (Include pregnancy within 3 months of death): Left side paralyzed 10 years	
Major findings: Of operation:	
Of autopsy:	

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

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? .....
While at work? ..... (Specify type of place) (e) Means of injury .....
23. Signature: E. H. Bensel M.D. (M. D. or other)
Address: Seymour Mo Date signed: 6-18-41

(Licensed Embalmer's Statement on Reverse Side)

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

OWENA MOORE

SUPPLEMENTAL

STA

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

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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

Please state cause and form of paralysis as cerebral hemorrhage, bulbar paralysis, paralysis agitans, etc.

Please write directly on the face of the supplemental, state date filed, and return at once. Thank you.

Harry F. Parker, M. D.
Special Agent, Bureau of the Census