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

FILED JUL 17 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

22101

State File No. \_\_\_\_\_

Registration District No. 508

Primary Registration District No. 3026

Registrar's No. 95

1. PLACE OF DEATH: Birnington  
 (a) County Birnington  
 (b) City or town Chillicothe  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: no st number 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution ✓  
 In this community 30 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 59  
 (a) State Mo (b) County Birnington  
 (c) City or town Chillicothe Mo  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. no st no  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? unknown years.

3. (a) PRINT FULL NAME Thomas J Nash  
 (b) If veteran, name war ✓  
 (c) Social Security No. ✓

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 20  
 year 1941 hour 9 minute 30 P, M.

4. Sex Male 5. Color or race white  
 6. (a) Single, widowed, married, divorced divorced  
 (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years  
 7. Birth date of deceased Mo 4 - 18 65  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 2, 1941, to July 20, 1941, that I last saw him alive on July 2, 1941, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
76 2 17 hr. min.

Immediate cause of death Pulmonary Tuberculosis 5 yrs  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

9. Birthplace Norway 4  
 (City, town, or county) (State or foreign country)

Other conditions 12/8  
 (Include pregnancy within 3 months of death)

10. Usual occupation Farmer  
 11. Industry or business ✓

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER  
 12. Name Unknown  
 13. Birthplace Norway 4  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Norway 4  
 (City, town, or county) (State or foreign country)

16. (a) Informant Thomas E. Stoltz  
 (b) Address Samuel mo

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof 6-22-41  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation mt Pleasant

(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? \_\_\_\_\_

18. (a) Signature of funeral director Geo D's ozon  
 (b) Address Chillicothe mo  
 19. (a) JUNE 21-41 (b) Theresa M.D.  
 (Date received local registrar) (Registrar's signature)

23. Signature G. J. Allen (M. D. or other) \_\_\_\_\_  
 Address Chillicothe mo Date signed 6/21/41

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**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 with the above constitutes grounds for revocation of license.)**

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