

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22269

State File No.

Registration District No. 605

Primary Registration District No. 4359

Registrar's No.

1. PLACE OF DEATH:

(a) County NEW MADRID
 (b) City or town RURAL Winn
 (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 _____
 In this community BORN IN IT (Specify whether years, months or days)

8. (a) PRINT FULL NAME DUVILLA EAY NICHOLS

8. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased 6 2 1941
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 4 If less than one day hr. _____ min.

9. Birthplace MO 0
 (City, town, or county) (State or foreign country)

10. Usual occupation NON

11. Industry or business NON

12. Name W. L. NICHOLS

13. Birthplace MISS
 (City, town, or county) (State or foreign country)

14. Maiden name HELEN MAY ISBELL

15. Birthplace MISS
 (City, town, or county) (State or foreign country)

16. (a) Informant W. L. NICHOLS

(b) Address LILBOURN, MO R. 1

17. (a) BURIED (b) Date thereof 6.6 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation KEWANEE MO

18. (a) Signature of funeral director J. M. Hill

(b) Address Lilbourn, Mo R. 1

19. (a) 6/7/41 (b) D. G. W. Husted
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid
 (c) City or town Lilbourn R. 1
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6
 year 1941 hour 2 minute 30 M.

21. I hereby certify that I attended the deceased from June 2, 1941, to June 6, 1941;
 that I last saw him alive on June 4, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition

Due to Baby was very weak from mother's illness
 Due to of colitis.

Other conditions (Include pregnancy within 3 months of death) - 150

Major findings: Of operations _____

Of autopsy _____

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) (a) Means of Injury 0

23. Signature D. G. W. Husted (M. D. or other)

Address Parma, Mo Date signed 6/7/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

2
3
X2, 192

MOTHER FATHER

RECEIVED

District Health Officer No. 2,

District File Number 741-893

Date Filed 7/15/41

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, above space should be left blank.