

No. 2  
5-42  
17-39  
X32873

Registration District No. **137**

Primary Registration District No. **4218**

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

1. PLACE OF DEATH:

(a) County Windsor

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

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

(d) Length of stay: In hospital or institution 35 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME William Henry Nine

3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Helena Garber Nine 6. (c) Age of husband or wife if alive, \_\_\_\_\_ years

7. Birth date of deceased June 26 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

78 8 17 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farming (Retired)

11. Industry or business \_\_\_\_\_

12. Name Daniel Nine

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

14. Maiden name Sarah Davidson

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

16. (a) Informant W. E. Nine

(b) Address Windsor, Missouri

17. (a) Burial (b) Date thereof 3-14-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Windsor, Missouri

18. (a) Signature of funeral director Huston-Turner

(b) Address Windsor, Missouri

19. (a) March 17, 1943 (b) Georgia Kitcher  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry

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

(d) Street No. 407 East Jackson  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13  
year 1943 hour 1:00 minute \_\_\_\_\_ a.m.

21. I hereby certify that I attended the deceased from March 12, 1943, to March 12, 1943, that I last saw him alive on March 12, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Acute nephritis Duration 2 days

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy None

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 J.A. Beckwith M. D. or other M.D.

Address Windsor Date signed 3-13-43

1067

RECEIVED

District Health Officer No. 71

District File Number 3-43-108

Date Filed 4-13-43

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.....

*Edwill Hudson*

Licensed Embalmer No. 3391

P. O. Address.....

*Windsor, Me*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10240

Registration District No. 137

Primary Registration District No. 4218

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Henry  
(b) City or town Windsor  
(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  
In this community years, months or days)

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

Wm Henry mine

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased

June 26 1874  
(Month) (Day) (Year)

8. AGE:

Years 78

Months 8

Days

If less than one day

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry of business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

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 March 3  
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from  
that I last saw him alive on  
and that death occurred on the date and hour stated above.  
Immediate cause of death acute nephritis  
following chronic nephritis

Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death)  
131 lb.

Duration 10 yrs.

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?

While at work? (Specify type of place) (e) Means of injury  
23. Signature J.A. Backman (M.D. or other) MD  
Address Date signed

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

MOTHER FATHER

SUPPLEMENTARY

