S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 10 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41421

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 331

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 314 N Florence 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 Life time
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair 2
(c) City or town Kirksville Mo 2
(If outside city or town limits, write "RURAL")
(d) Street No. 314 N. Florence
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country — 0

3. (a) PRINT FULL NAME Mary Jane Nicolson
3. (b) If veteran, name war —
3. (c) Social Security No. 496-18-3681 496-18-3681
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S 0
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Mar (Month) 19 (Day) 1888 (Year)

8. AGE: Years 55 Months 9 Days 7 If less than one day ..... hr. ..... min.

9. Birthplace Stuttgart (City, town, or county) Ark 1 (State or foreign country)
10. Usual occupation Bank Cashier
11. Industry or business
FATHER
12. Name S. D. Nicolson
13. Birthplace (City, town, or county) Mo 0 (State or foreign country)
MOTHER
14. Maiden name Martha D. Harrison
15. Birthplace (City, town, or county) Mo 0 (State or foreign country)
16. (a) Informant Pearl Nicolson
(b) Address 416 N Florence
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 (Month) 28 (Day) 43 (Year)
(c) Place: burial or cremation Forest Cem.
18. (a) Signature of funeral director Summers & Powell
(b) Address Kirksville Mo
19. (a) 12/30/43 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 26 year 1943 hour 12 minute 05 A.M.
21. I hereby certify that I attended the deceased from October 24, 1940 to December 26, 1943; that I last saw her alive on December 26, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	4 days.
Cerebral Hemorrhage	6½ mon.
Due to Hypertension with Chronic Glomerular Nephritis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

131 b

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 2
23. Signature Howard E. Gross (M. D. or other) DD.
Address Kirksville Mo. Date signed 12-30-43

1049

(Licensed Embalmer's Statement on Reverse Side)

APR 18 1944

RECEIVED
District Health Officer No. 10
District File Number 1-44-28
Date Filed JAN 7 1944

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 W. C. Summers

Licensed Embalmer No. 2159

P. O. Address Linksville 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.