

1-4-41  
5-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

42899

State File No. ....

Registrar's No. ....

FILED JAN 4 1944

Registration District No. 198

Primary Registration District No. 0718

**1. PLACE OF DEATH:**  
 (a) County McDonald  
 (b) City or town Rural Prairie Twp  
(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: 17 1/2 hrs  
(Specify whether In this community years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State: Mo (b) County: McDonald  
 (c) City or town: 1  
(If outside city or town limits, write "RURAL")  
 (d) Street No.: 1  
(If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country: 0

**3. (a) PRINT FULL NAME** Nellie Pickett  
 3. (b) If veteran, name war: 1  
 3. (c) Social Security No.: 1

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month March day 27  
 year 1943 hour 11 minute 50 p.m.

4. Sex Female 5. Color or race white  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife James E. Pickett  
 6. (c) Age of husband or wife if alive 64 years  
 7. Birth date of deceased: Nov 10 - 1875  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1 - 1 - 1943 to Mar 22 - 1943  
 that I last saw her alive on Mar 14 1943  
 and that death occurred on the date and hour stated above.

**8. AGE:**  
 Years 67 Months 4 Days 12  
 If less than one day hr. min.

Immediate cause of death: Coronary heart failure  
 Due to: Chronic Valvular heart disease + hypertension  
 Due to: 1  
 Other conditions: 1  
(Include pregnancy within 3 months of death)

9. Birthplace: Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: 1

**MOTHER FATHER**  
 12. Name: Benjamin Wilks  
 13. Birthplace: Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name: Mary Dowling  
 15. Birthplace: Ill  
(City, town, or county) (State or foreign country)

16. (a) Informant: J. E. Pickett  
 (b) Address: Southwest City Mo

17. (a) 1 (b) Date thereof: 3-24-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation: Southwest City Mo

18. (a) Signature of funeral director: Chas. L. Williams  
 (b) Address: Woodson Ave

19. (a) 4-1-43 (b) John W. Nicholas  
(Date received local registrar) (Registrar's signature)

Major findings: 924  
 Of operations: 1  
 Of autopsy: 1

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) 1  
 Date of occurrence: 1  
 (c) Where did injury occur? 1 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work? 1 (Specify type of place) (e) Means of injury: 1  
 23. Signature: C. F. Walker (M. D. or other) 1  
 Address: Union Okla Date signed: 3.23.43

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

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

1836

(Licensed Embalmer's Statement on Reverse Side)

SEP 16 1954

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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.**

Registration District No. 198 Primary Registration District No. 5718

1. PLACE OF DEATH:

(a) County McDonald  
(b) City or town Rural Prairie Twp.  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Nellie Pickett  
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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Nov. 10  
(Month) (Day) (Year)

8. AGE: Years 67 Months 4 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald  
(c) City or town Rural Prairie Twp.  
(If outside city or town limits, write "RURAL")  
(d) Street No. Route #1 Southwest City, Mo.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 2  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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

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

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

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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

5-42899.