

FILED AUG 3 1944

Registration District No. 108

Primary Registration District No. 5423

Registrar's No. 74

1. PLACE OF DEATH

(a) County Dunklin
(b) City or town Atty. Mo. Rural Salem
(If outside city or town limits, write "RURAL" and name of township) N.W.P.
(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 1
(Specify whether
In this community 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin
(c) City or town Atty. Mo. Rural Salem Twp
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11
year 1944 hour 9 minute 55 A.M.
21. I hereby certify that I attended the deceased from Feb 10
1944 to Feb 11 1944
that I last saw her alive on Feb 10 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration DK
Due to Hypertension DI

Other conditions (Include pregnancy within 3 months of death)

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 M.C. Glasgow (M. D. or other)
Address Cardwell Date signed 2-11-44

3. (a) PRINT FULL NAME Lucille Louise Nicholson

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

4. Female 5. Color or race 6. (a) Single, widowed, married, divorced 9

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

7. Birth date of deceased Nov 6 1850
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
93 11 21 hr min.

9. Birthplace Nelson Ill
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Not known
13. Birthplace Not known 9
(City, town, or county) (State or foreign country)

14. Maiden name Not known
15. Birthplace Not known 9
(City, town, or county) (State or foreign country)

16. (a) Informant Lucille Nicholson

(b) Address Sennett, Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof Feb 12 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Paulo Cemetery

18. (a) Signature of funeral director M.C. Daniel

(b) Address Sennett, Mo.

19. (a) 7-11-1944 (b) H. O. Sterry
(Date received local registrar) (Registrar's signature)

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

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.....

not embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Arthur J. McDaniel

Licensed Embalmer No. *2093*

P. O. Address *Senath 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.

Registration District No. 108

Primary Registration District No. 5423

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

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Rural Salem Twp.
(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)

3. (a) PRINT FULL NAME Lottie L. Nicholson

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

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

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

7. Birth date of deceased: Mar (Month) 11 (Day) 1913 (Year)

8. AGE: Years 93 Months _____ 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation Lulu Cemetery

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-11-1944 (b) H.O. Sterey
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him _____ 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 _____

Duration

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 _____ (M. D. or other) _____

Address _____ Date signed _____

~~10/17~~ 10/17