

FILED DEC 25 1944

Registration District No. _____

Primary Registration District No. **3010**

Registrar's No. **388**

1. PLACE OF DEATH:

(a) County **Cape Girardeau**

(b) City or town **Cape Girardeau, Missouri**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1500 S. Sprigg St. (Home)**
(If not a hospital or institution, write street number or location)

(d) Length of stay: **In hospital or institution. Not in hospital**
(Specify whether)

In this community **Several years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cape Girardeau**

(c) City or town **Cape Girardeau**
(If outside city or town limits, write "RURAL")

(d) Street No. **500 S. Sprigg St.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Charles Andrew Nations**

3. (b) If veteran, name war **no**

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November**, day **16**
year **1944** hour **7:00 A.M.** minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____.

4. Sex **Male**

5. Color or race **White**

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

6. (b) Name of husband or wife **Wife is dead**

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

7. Birth date of deceased: **June 3rd 1863**
(Month) (Day) (Year)

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

8. AGE: Years **81** Months **5** Days **13** If less than one day hr. _____ min. _____

Immediate cause of death **Chronic myocarditis Due to senility** Duration _____

9. Birthplace **Perry County Missouri**
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

Other conditions **93d**
(Include pregnancy within 3 months of death)

10. Usual occupation **Fruit peddler**

11. Industry or business **Retired**

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name **Matches Nations**

13. Birthplace **Unknown** **U**
(City, town, or county) (State or foreign country)

14. Maiden name **Nancy Do not know**

15. Birthplace **Unknown** **A**
(City, town, or county) (State or foreign country)

16. (a) Informant **See Ray Nations**

(b) Address **Tiboney St, Cape Girardeau, Mo.**

17. (a) **Removal** (b) Date thereof **11/19/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cinder Grove yard**

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? _____

18. (a) Signature of funeral director **Bespinghoff**

(b) Address **Chaffin**

19. (a) **11-22-44** (b) _____
(Date received local registrar) (Registrar's signature)

While at work? _____

(c) Means of injury **Coroner**

23. Signature **Dr. J. P. Sigmond** (M.D. or other) _____

Address **Jackson, Mo.** Date signed **11/20/44**

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

6
4

10 14

RECEIVED

District Health Officer No. 4
District File Number 1244-4661
Date Filed 12-7-44

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.....

Wm. R. Kasper

Licensed Embalmer No. 3242

P. O. Address Chiffon

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.