U. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 11 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

Dr. Doubler

State File No. 10423

Registrar's No. 344

1. PLACE OF DEATH:
(a) County: GREENE
(b) City or town: Springfield (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Burge Hosp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 Days; In this community 35 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene
(c) City or town: Springfield (If outside city or town limits, write "RURAL")
(d) Street No.: 315 E. McDaniel (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country: Syria

3. (a) PRINT FULL NAME: Nicholas E. Malick
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: none
6. (c) Age of husband or wife if alive: X X years
7. Birth date of deceased: Unk. (Month) Unk. (Day) 1894 (Year)
8. AGE: Years 51; Months Unk.; Days Unk.; If less than one day: hr. min.
9. Birthplace: Lebanon (City, town, or county); Syria (State or foreign country)
10. Usual occupation: Importer
11. Industry or business:
MOTHER FATHER
12. Name: Anton Malick
13. Birthplace: Unk. (City, town, or county); Syria (State or foreign country)
14. Maiden name: Markie Unk.
15. Birthplace: Unk. (City, town, or county); Syria (State or foreign country)
16. (a) Informant: Burge Hospital
(b) Address: Spfd., Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-25-45 (Month) (Day) (Year)
(c) Place: burial or cremation: MAPLE PARK.
18. (a) Signature of funeral director: H.H. Lohmeyer
(b) Address: Springfield, Mo.
19. (a) 4-23-45 (Date received local registrar) (b) E W Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21 year 1945 hour 5 minute 30 pm.
21. I hereby certify that I attended the deceased from 3/3, 1945, to 4/21, 1945; that I last saw him alive on 4/21, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Diabetic gangrene of left foot	6 wks
Due to: Diabetes	20 yrs
Due to: Unable to stand amputation operation	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: Diabetic gangrene 1st foot	
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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: N. Doubler (M. D. or other)
Address: Springfield, Mo. Date signed 4/23/45

(Licensed Embalmer's Statement on Reverse Side)

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. 3457

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.