. S. No. 2
0M—2-43
v. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30677

FILED SEP 22 1945

Registration District No. 77 Primary Registration District No. 5551 Registrar's No. 89

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains Howell Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: County Farm R F D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 24 hrs
years, months or days)

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

3. (a) PRINT FULL NAME Harry Nale
3. (b) If veteran, name war World War I
3. (c) Social Security No. .....
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Josephine Nale
6. (c) Age of husband or wife if living, deceased ..... years
7. Birth date of deceased 7-1-1896 (Month) (Day) (Year)

8. AGE: Years 49 Months 1 Days 4 If less than one day ..... hr. ..... min.

9. Birthplace Howell Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer Merchant
11. Industry or business .....

MOTHER
12. Name Emanuel M. Nale
13. Birthplace Illinois (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Nettie Davis
15. Birthplace Mo (City, town, or country) (State or foreign country)

16. (a) Informant Maude McCracken
(b) Address Layton, Mo.
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof 8-8-45 (Month) (Day) (Year)
(c) Place: burial or cremation Nottfield Cemetery
18. (a) Signature of funeral director Roberts
(b) Address West Plains Mo.
19. (a) 8-20-45 (Date received by local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 5 year 1945 hour about three o'clock A. M.

21. I hereby certify that I attended the deceased from July 29th, 1945 to Aug. 5th, 1945 that I last saw him alive on July 29, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration 2 wks
Slow hemorrhage
Due to Lues
Due to .....
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations .....
Of autopsy 30 Y

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 A. Thornburgh M. D. or other
Address West Plains, Mo. Date signed 8/13/4

(Licensed Embalmer's Statement on Reverse Side) Thornburgh

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

RECEIVED
District Health Officer No. 5,
District File Number 945-389
Date Filed 9-21-45

SEP 27 1945

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 P D Roberts

Licensed Embalmer No. 3435

P. O. Address Mexico, 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.