. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

36728

State File No.

FILED NOV 28 1945

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 309

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Poplar Bluff, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Lucy Lee Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 8 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler 12

(c) City or town Poplar Bluff, Mo. 7
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) Citizen of foreign country? — 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Walter Dow Nixon

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married, divorced 2 widow

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan., (Month) 24 (Day) 1875 (Year)

8. AGE: Years 70 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Butler County (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Frank Nixon
13. Birthplace (City, town, or county) Ky. 1 (State or foreign country)

MOTHER
14. Maiden name unknowen Ky.
15. Birthplace (City, town, or county) Ky. 1 (State or foreign country)

16. (a) Informant Wm D. Nixon
(b) Address 4827 Washington Blvd. Chicago, Ill.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/45 (Month) (Day) (Year)
(c) Place: burial or cremation Cochran Cem.

18. (a) Signature of funeral director William P. Beary
(b) Address Corning, Ark.

19. (a) 11/3/45 (Date received local registrar) (b) R H Minehee (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29, year 1945 hour 8 minute 20AM M.

21. I hereby certify that I attended the deceased from October 25, 1945 to October 29, 1945; that I last saw him alive on October 29, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxiation

Due to Cardiac failure

Due to Cardio-Vascular-renal disease.

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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature A D Markel MD (M. D. or other)

Address Poplar Bluff Date signed 10/29-45

1422

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1145-3282
Date Filed 11-8-45

Removed body to Ark., to be prepared for burial

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 William P. Peary

Licensed Embalmer No. 728 Ark.

P. O. Address Corning, Ark.

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.