

FILED JAN 25 1946

State File No. \_\_\_\_\_

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 240

## 1. PLACE OF DEATH:

(a) County Randolph  
 (b) City or town Moberly  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Woodland Hospital 0  
 (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 Robert D. Nise

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

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 6. (d) Age of husband or wife if dead \_\_\_\_\_ years  
 7. Birth date of deceased May 28 1890  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
 . . . 45 6 3 hr. \_\_\_\_\_ min.

9. Birthplace Mo 0  
(City, town, or county) (State or foreign country)10. Usual occupation Rtd Tinner11. Industry or business Self

MOTHER FATHER { 12. Name Hamp Nise  
 13. Birthplace Mo 0  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Blanche Morris  
 15. Birthplace Mo 0  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Blanche Nise(b) Address Moberly, Mo17. (a) Burial (b) Date thereof Dec 3 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Moberly, Mo18. (a) Signature of funeral director Mahan and Son(b) Address Moberly19. (a) Dec 3-45 (b) Dean Bellinger  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph 0  
 (c) City or town Moberly  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 106 E. Carpenter  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15  
 year 1945 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from Nov 30  
 \_\_\_\_\_, 1945 to Dec 1, 1945  
 that I last saw him alive on Dec 1, 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death acid intoxication 7 days  
 Duration  
 Due to diabetes mellitus 6 yrs.

Due to \_\_\_\_\_  
 Other conditions Nephritis  
 (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)  
 (a) Means of injury \_\_\_\_\_  
 23. Signature J. W. H. Herring M.D.  
 Address Woodland Hospital Date signed 3 Dec 45

6781 B NUP

JAN 20 1941

RECEIVED  
District Health Officer No. 10  
District File Number 1-46-107  
Date Filed JAN. 23. 1946

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 *Frank S. D. Hutt*

Licensed Embalmer No. 3021

P. O. Address *Mobily, 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.

FILE BY

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb  
Registrar's No. 240

Registration District No. 294 Primary Registration District No. 3056

1. PLACE OF DEATH:

(a) County Handolph

(b) City or town Moberly  
(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 Robert D. Rice

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

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased: May 28 1920  
(Month) (Day) (Year)

8. AGE: Years 45 Months \_\_\_\_\_ Days \_\_\_\_\_ (Less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ 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)

(c) Place: burial or cremation \_\_\_\_\_

(a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

(a) \_\_\_\_\_ (b) \_\_\_\_\_ (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 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ that I last saw him alive on \_\_\_\_\_ and that death occurred on the date and hour stated above. \_\_\_\_\_

Duration \_\_\_\_\_

Due to Nephritis, Chronic

Due to cause undetermined

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) (c) Means of injury \_\_\_\_\_

23. Signature W. H. Henry M. D. \_\_\_\_\_

Address Washington Hospital Date signed 29 Feb

SUPPLEMENTARY

WRITE IN UNFADING BLACK INK—MAKE A PERMANENT RECORD

160794

JUN 8 1943

3.793

JAN 20 1941

JAN 20 1941