

S. No. 2
OM-5-43
v. 5-17-39
I X36671

16481

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 66

FILED JUN 13 1946
Registration District No. 139

Primary Registration District No. 5530

1. PLACE OF DEATH:
(a) County Holt
(b) City or town Rural, Benton Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mound City Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 77 years. (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Holt 44
(c) City or town Rural, Benton Twp.
(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 _____

3. (a) PRINT FULL NAME John Robert Nixon
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 10
year 1946 hour 8 minute 3 P M.
21. I hereby certify that I attended the deceased from May 7, 1946 to May 10, 1946
and that death occurred on the date and hour stated above.
that I last saw him alive on May 19, 1946

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Laura Nixon 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased Nov. 24 1868
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage
Duration _____

8. AGE: Years 77 Months 5 Days 16
If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy John

9. Birthplace Holt County, Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business George Nixon
12. Name Ireland
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Crawford
15. Birthplace Ireland

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?

16. (a) Informant Mrs. Laura Nixon
(b) Address Burial 5/13/46
(c) Place: burial or cremation Mt. Hope Cemetery
18. (a) Signature of funeral director Mt. Crawford
(b) Address Mound City, Mo.
19. (a) 5-13-46 (b) John
(Date received local registrar) (Registrar's signature)

23. Signature DB Perry (M. D. or other) MD
Address Mound City, Mo Date signed 5-11-46

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

4
5
0

10000

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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..... *J. H. Crawford*.....
Licensed Embalmer No. *1824*.....
P. O. Address, *Manassas City Md*.....

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.