

Registration District No. 141

Primary Registration District No. 3025-5531

State File No. _____

Registrar's No. 8

1. PLACE OF DEATH:
 (a) County Howell
 (b) City or town Ott, Ark Rural
 (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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Howell 46
 (c) City or town Ott, Ark Rural
 (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 Betty Lee Nicks
 (b) If veteran, name war _____ (c) Social Security No. ✓

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 24
 year 1946 hour 4 minute A.M.

4. Sex 71 5. Color or race W
 6. (a) Single, widowed, married, divorced Child
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 10 - 1941
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-22, 1946 to 11-24, 1946
 that I last saw him alive on 11-23, 1946
 and that death occurred on the date and hour stated above.

8. AGE: Years 5 Months 6 Days 14
 If less than one day _____ hr. _____ min.

Immediate cause of death Unknown
 Duration _____

9. Birthplace Howell Co Mo
 (City, town, or county) (State or foreign country)?

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation Child

Major findings: Of operations _____ Of autopsy _____

MOTHER FATHER
 11. Industry or business _____
 12. Name John Nicks
 13. Birthplace Ott Ark
 (City, town, or county) (State or foreign country)
 14. Maiden name Lydia Murdock
 15. Birthplace unk
 (City, town, or county) (State or foreign country)

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

16. (a) Informant John Nicks
 (b) Address Ott, Ark
 17. (a) B (Burial, cremation, or removal) (b) Date thereof 11-24-46
 (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Free Union
 18. (a) Signature of funeral director Robertson
 (b) Address West Plains, Mo
 19. (a) Dec 6-46 (Date received local registrar) (b) Beatrice Cook (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature V. C. E. Roe (M. D. or other) _____
 Address Viola Ark Date signed _____

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.....

Betty Lee Nicko

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

H. D. Robertson

Licensed Embalmer No.....

3435

P. O. Address.....

West Plains, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 102

Registration District No. 141

Primary Registration District No. 3556

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Otto Ark Rural
(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 Betty Lee Rich

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased..... (Month) (Day) (Year)

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

9. Birthplace..... (City, town, or county) (State or foreign country) MO

10. Usual occupation.....

11. Industry or business.....

MOTHER, FATHER { 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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) Beatrice Cook (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
(c) City or town Otto Ark
(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..... day..... year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19....., and that death occurred on the date and hour stated above. Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

MAKE A PERMANENT RECORD

2B
45
3880

40410