

**FILED APR 10 1947**  
127

Registration District No. **127** Primary Registration District No. **5452**

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

1. PLACE OF DEATH:

(a) County **Greene**

(b) City or town **Ash Grove R.R.**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Residence 1**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community **Native** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene** **39**

(c) City or town **Ash Grove R.R.**  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Alonzo D. Nicholson**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **2**  
year **1947** hour **9** minute **20 A.M.**

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive **1** years

7. Birth date of deceased **3 - 24 1866**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **3 - 31 1947** to **4 - 2 1947**  
that I last saw **in** alive on **4 - 1 1947**  
and that death occurred on the date and hour stated above.

8. AGE: Years **81** Months **0** Days **9** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Whisper poisoning**  
Due to **proliferates**

9. Birthplace **Greene Co. Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

Other conditions (Include pregnancy within 3 months of death) **390**

MOTHER FATHER { 11. Industry or business \_\_\_\_\_

12. Name **David D. Nicholson**

13. Birthplace **Mo**  
(City, town, or county) (State or foreign country)

14. Maiden name **Martha E. Johns**

15. Birthplace **Tenn**  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

16. (a) Informant **Bill Nicholson**  
(b) Address **Miller Mo 4/3**

17. (a) **Burial** (b) Date thereof **4-2-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Prospect**

18. (a) Signature of funeral director **Marion - Jensen**  
(b) Address **Ash Grove Mo.**

19. (a) **4/3/47** (b) **Bill Johns**  
(Date received local registrar) (Registrar's signature)

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 **W. P. Beasley** (M. D. or other) **Mo**  
Address **Miller Mo** Date signed **4-2-47**

RECEIVED

Greene County Health Office,

County File Number 47-4-42

Date Filed 4-9-47

*Handwritten notes and signatures:*  
L. R. Leiman  
Miller Co.  
P.O. Address  
81  
P.O. No. 3297  
Miller Co.

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

L. R. Leiman  
Licensed Embalmer No. 3297

P.O. Address Miller Co.

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.