No. 2
8-43
7-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 22 1948

Registration District No. 375

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11338

Primary Registration District No. 6280

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Wright

(b) City or town Hart Twp - 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: 114

(a) State Missouri (b) County Wright 0

(c) City or town Hart Twp - Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. 8 Miles NW of Mansfield 0
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Clara Ellen Nichols

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife W H Nichols

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

7. Birth date of deceased W H Nichols (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
89	2	21	..... hr. ..... min.

9. Birthplace Mason City (City, town, or county) Illinois (State or foreign country) /

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name James Saffer
13. Birthplace Mason City (City, town, or county) Illinois (State or foreign country) /

MOTHER
14. Maiden name Nancy Wright
15. Birthplace Not Known (City, town, or county) — (State or foreign country) 9

16. (a) Informant Mrs Sadie Cummings
(b) Address Emporia Kans

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 21 1948 (Month) (Day) (Year)
(c) Place: burial or cremation Emporia Kans

18. (a) Signature of funeral director F. G. Sleffe
(b) Address Mansfield Mo

19. (a) Mar. 2, 1948 (Date received local registrar) (b) E. C. Garner (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb day 20
year 1948 hour 4 minute P M.

21. I hereby certify that I attended the deceased from Dec 1, 1947 ~~1948~~ to Feb 28, 1948
that I last saw her alive on Dec 1, 1947 ~~1948~~
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arterial Sclerosis	Sev yr
Due to	
Due to	
Other conditions: General Sacoma (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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

DIVISIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 J. A. Fuson (M. D. or other)
Address Mansfield Mo Date signed Feb 20, 48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 348-312
Date Filed MAR 18 1948

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 Gene E Holdren

Licensed Embalmer No. 3865

P. O. Address Hartville, Mo

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

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

No. 2B
—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 375 Primary Registration District No. 6280 Registrar's No. 10

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Wright

(b) City or town 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 (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

3. (a) PRINT FULL NAME Clara E. Nichols

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 Wid

6. (b) Name of husband or wife

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

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

8. AGE: Years 89 Months 2 Days 21 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20
year 1948 hour minute M.

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

	Duration
Immediate cause of death Stomach & Liver	
Due to	
Due to	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature J A Fuson (M. D. or other)
Address Mansfield Mo Date signed 4-27-48

S-11332