

V. S. No. 2
5CM-5-42
Rev. 5-17-39
P-1 X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15286**

FILED APR 26 1948
Registration District No. **572**

Primary Registration District No. **4547**

Registrar's No. **13**

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

13
1
0

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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Worth
 (c) City or town Grant City, Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. In city
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Sam Nail
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Cor Jane Nail
 6. (c) Age of husband or wife if alive deceased years
 7. Birth date of deceased April 26 1856
(Month) (Day) (Year)

8. AGE:
 Years 91 Months 11 Days 11
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Carpenter

11. Industry or business Carpenter

12. Name Henry Nail

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

14. Maiden name Lucena Swift

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

16. (a) Informant Late Nail

(b) Address Grant City, Mo.

17. (a) Burial (b) Date thereof April 9-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant City, Cemetery

18. (a) Signature of funeral director John Anderson
 (b) Address Grant City, Mo.

19. (a) April 13, 1948 (b) Letha E. Dawson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 4 day 6
 year 1948 hour 3 minute 40 P.M.
 21. I hereby certify that I attended the deceased from 3-20
 _____, 1948 to 4-6, 1948
 that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death: Peptic ulcer
 Other conditions: Myocardial infarction of heart
 (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations: _____
 Of autopsy: no

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 J. H. H. M.D. (M. D. or other)
 Address Grant City, Mo. Date signed 4-7-48

Duration 2 yrs.
 PHYSICIAN 5 yrs.
 Underline the cause to which death should be charged statistically.

DISTRICT HEALTH OFFICE
Canton, 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.....

John Andrews....., Registered Apprentice No.....
working under my personal supervision.

Signed *John Andrews*.....
Licensed Embalmer No. *4211*.....
P. O. Address *Grant City 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.