

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

29865

1. PLACE OF DEATH

County Vernon
Township Badger
City Nevada

Registration District No. 875
Primary Registration District No. 6161

File No. _____
Registered No. 208
St. _____ Ward _____

2. FULL NAME

William Adalbert Nickson

(a) Residence. No. R-3-D-2 St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. da. How long in U.S., if of foreign birth? Born mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna May Nickson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 28 - 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>68</u>	<u>9</u>	<u>17</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) Edwardsville
(STATE OR COUNTRY) Illinois

10. NAME OF FATHER John Nickson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY) D K

12. MAIDEN NAME OF MOTHER Caroline Goodenough

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ann Arbor
(STATE OR COUNTRY) Michigan

14. INFORMANT Anna M. Anderson
(Address) Nevada 210 RFD #2

15. FILE NO. 9-4-29 REGISTRAR E. R. King

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 15 - 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS
Free from Food-Poison
Dropped to death

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) M. E. Ferry Coroner 8/16, 1929 (Address) Nevada Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Newton Cemet DATE OF BURIAL 8/19/1929

20. UNDERTAKER Ferry Funeral Home Nevada Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHILE FURNISHING INFORMATION TO THE BUREAU OF VITAL STATISTICS, THE DECEASED IS DEEMED TO BE UNDER THE CARE OF THE BUREAU OF VITAL STATISTICS.

