

DEC 15 1938

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

40457  
Do not use this space.

1. PLACE OF DEATH

(a) County Pemiscott 2 Registration District No. 126  
(b) Township Coates Primary Registration District No. 126 Registered No. \_\_\_\_\_  
(c) City Coates (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

242 Jason W. Nichols  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 2, 1881

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hrs. or .....min.  
58 2 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark 1

FATHER 13. NAME Billy Nichols

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

MOTHER 15. MAIDEN NAME S

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 1

17. INFORMANT Mrs Ethel Harris (ADDRESS) Keale Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Payer Ark DATE 11-5 1938

19. FUNERAL DIRECTOR (NAME) Holt Funeral Home (ADDRESS) Boyettsville Ark

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 4 1938

22. I HEREBY CERTIFY, That I attended deceased from July 19 1937, to 11-4 1938  
I last saw him alive on 10-28 1938. Death is said to have occurred on the date stated above, at 1 A. m.  
The principal cause of death and related causes of importance were as follows:

Chronic Cardio-renal disease  
Hypertension - Nephritis

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Lab. Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19 \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? NO  
If so, specify \_\_\_\_\_  
(Signed) H. E. Cooper, M. D.  
Coates Mo. (Address)

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.

9562

RECEIVED

District Health Officer No. 5

District File Number 1239-6

Date Filed 12/8/39

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

40487  
Do not use this space.

1. PLACE OF DEATH

(a) County Camden Registration District No. 656  
 (b) Township Courts Primary Registration District No. 2873 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jason W. Nichols

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W  
(write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 4, 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Orelia Jane Nichols

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 2 1881

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS 58 MONTHS 2 DAYS 2 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
 11. Total time (years) spent in this occupation \_\_\_\_\_

Chronic Cardiac Renal Disease  
 Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) arsc

Other contributory causes of importance:  
hypertension nephritis

FATHER 13. NAME Billy Nichols

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

MOTHER 15. MAIDEN NAME Rosie Aschcraft

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

17. INFORMANT (ADDRESS) Mrs. J. H. Harris  
St. Louis

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL PLACE Pages arsc DATE 11-5-39

Specify whether injury occurred in industry, in home, or in public place.

19. FUNERAL DIRECTOR (ADDRESS) Holt Funeral Home  
St. Louis arsc

Manner of injury \_\_\_\_\_

20. FILED 2-1 40 Tom Bugance  
Local Registrar

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) H. E. Cooper, M. D.

(Address) Carter

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Every item of information should be carefully supplied. AGE should be stated in years, months and days. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

4045-77  
Do not use this space.

1. PLACE OF DEATH

(a) County Peru Registration District No. 65-6  
(b) Township Centre Primary Registration District No. 3873 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Jason W. Nichols St.  \_\_\_\_\_  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED sm  
(write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 4, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
58 2 2

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_

11. Total time (years) spent in this occupation 131

Chronic Cardiac Renal Disease Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:  
Hypertension  
Chronic Cause Unknown

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) H. E. Cooper, M. D.

(Address) Coates

20. FILED \_\_\_\_\_, 19\_\_\_\_

Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
Every item of information should be carefully supplied. If any item is omitted, the certificate will be classified as "Cause of Death in plain terms," so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENT