

FILED MAR 12 1940

Registration District No. **318**

Primary Registration District No. **5440**

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town SPRINGFIELD, MISSOURI
(c) Name of hospital or institution: MEDICAL CENTER FOR FEDERAL PRISONERS
(d) Length of stay: In hospital or institution 1 yr. 8 Mo. 26 da
In this community 1 yr. 8 months, 26 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Washington (b) County _____
(c) City or town Seattle
(d) Street No. _____
(e) If foreign born, how long in U. S. A. ? _____ years.

8. (a) PRINT FULL NAME NISSIN, Herbert Grant

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Catherino 6. (c) Age of ~~husband~~ wife if alive 31 years

7. Birth date of deceased July 27 1900
(Month) (Day) (Year)

8. AGE: Years 39 Months 7 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation Salesman

11. Industry or business

MOTHER FATHER { 12. Name Hans C. Nissin
13. Birthplace Unknown Denmark
(City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Deceased

(b) Address _____

17. (a) Carl Loun Country (b) Date thereof 2 27 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Mo.

18. (a) Signature of funeral director E. W. Green

(b) Address Springfield, Mo.

19. (a) 2/27/40 (b) Chas. R. George M.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 24
year 1940 hour 4:00 minute 15 A.M.

21. I hereby certify that I attended the deceased from May 28, 1938, 19 , to February 24, 1940; that I last saw him alive on February 24, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculosis, pulmonary, chronic, far advanced, active Duration over 2 yrs

Due to _____
Due to 22

Other conditions Tuberculosis of Intestines same
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: Of operations _____
Of autopsy _____
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? _____

While at work? No (Specify type of place) (e) Means of injury _____
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Signature E. W. Green, (USPHS) (M. D. or D.O.)
Address Clinical Director MCFP Date signed _____

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

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.....
Self....., Registered Apprentice No.....
working under my personal supervision.

Signed.....*R. H. Chiens*.....

Licensed Embalmer No. *3687*.....

P. O. Address *Sp. 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, above space should be left blank.

X