

UG 21 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 25910

Registration District No. 653

Primary Registration District No. 4390

Registrar's No. 62

## 1. PLACE OF DEATH:

(a) County Pemiscot  
(b) City or town Hayti  
(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  
years, months or days) nine years3. (a) PRINT FULL NAME Stella Nichols 2423. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. no4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Atlas Nichols 6. (c) Age of husband or wife if alive 40 years7. Birth date of deceased Aug. 28 1902  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
37 10 9 hr. min.9. Birthplace Georgetown Ky.  
(City, town, or county) (State or foreign country)10. Usual occupation house wife

11. Industry or business \_\_\_\_\_

12. Name John C. Vance13. Birthplace Greensburg Ind.  
(City, town, or county) (State or foreign country)14. Maiden name Tlitha Neel15. Birthplace Georgetown Ky.  
(City, town, or county) (State or foreign country)16. (a) Informant Atlas Nichols(b) Address Hayti Mo.17. (a) burial (b) Date thereof July 9 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Hayti Mo.18. (a) Signature of funeral director Ray Undertaking Co.(b) Address Hayti Mo.19. (a) 7/8/40 (b) Pearl Kelley  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot(c) City or town Hayti  
(If outside city or town limits write "RURAL")(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7th,  
year 1940 hour 9 minute 15 P. M.21. I hereby certify that I attended the deceased from Feb 18, - 40  
July 7, 1940,  
that I last saw her alive on July 7, 1940,  
and that death occurred on the date and hour stated above.Immediate cause of death  
Carcinoma, affecting  
uterus, and other organs 5110  
Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations CarcinomaOf autopsy none

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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 W. H. Limberg (M. D. or other)Address Hayti Mo Date signed 9/9/40

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

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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 25-910

Registration District No. 653

Primary Registration District No. 4390

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
(a) County Peru  
(b) City or town Hayti  
(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 (Specify whether

3. (a) PRINT FULL NAME Stella 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 in  
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 37 Months 10 Days 9 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

**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) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month July day 7 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Carcinoma affecting uterus and other organs  
This diagnosis was made \_\_\_\_\_  
in a \_\_\_\_\_  
Hospital - N. M. I. I.  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 W. R. Linbaugh (M. D. or other) \_\_\_\_\_  
Address Hayti, Mo. Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

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

