

Registration District No. 605

Primary Registration District No. 4359

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

1. PLACE OF DEATH:

(a) County NEW MADRID  
 (b) City or town RURAL  
 (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 9 Months  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid  
 (c) City or town Lilbourn Rt 1  
 (If outside city or town limit, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME HELLEN MAY NICHOLS

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife WILLIAM NICHOLS 6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased MARCH 25 1917  
 (Month) (Day) (Year)

8. AGE: Years 1921 Months MAY Days 21 If less than one day  
 hr. min.

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

10. Usual occupation HOUSE WIFE

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

12. Name CLARENCE ISEBELL

13. Birthplace Printer MISS MOORE  
 (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant W.L. NICHOLS

(b) Address LILBOURN MO

17. (a) MISS FOR BURIAL (b) Date thereof 6.8 1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SILONE CEMETARY

18. (a) Signature of funeral director McNill  
 (b) Address Lilbourn Mo 534

19. (a) 6/8/41 (b) Dr. G. W. ...  
 (Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8  
 year 1941 hour 1 minute 00 M.

21. I hereby certify that I attended the deceased from June 2  
1941, to June 8, 1941;  
 that I last saw her alive on June 8, 1941;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Stes Colitis

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

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

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 Dr. G. W. ... (M. D. or other)

Address Parma Mo Date signed 6/8/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Officer No. 2,  
District File Number 741-894  
Date Filed 7/15/41

**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 *J. Hill*  
Licensed Embalmer No. 2627  
P. O. Address *Silbourn H/O*

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.

Registration District No. 605

Primary Registration District No. 4359

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town \_\_\_\_\_  
(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)

3. (a) PRINT FULL NAME Hellen May 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 m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 21, 1937  
(Month) (Day) (Year)

8. AGE: Years 20 Months 4 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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 \_\_\_\_\_

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)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 6-8-41 (b) D. Stewart Husted  
(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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

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

MOTHER FATHER

