

S. No. 2
M-9-41
v. 5-17-39
WI X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33598

FILED NOV 13 1948

State File No.

Registration District No. 78

Primary Registration District No. 5369

Registrar's No. 25

31
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0

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

1. PLACE OF DEATH:

(a) County Darless Sheridan Twp

(b) City or town Rural
(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 60 yrs years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Darless

(c) City or town Kidder Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Unknown Sheridan Twp
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country. _____

3. (a) PRINT FULL NAME Lucetta J. Nolpe

3. (b) If veteran, name war /

3. (c) Social Security No. /

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9 year 1948 hour 12:40 minute _____ A. M.

4. Sex 7 1

5. Color or race W

6. (a) Single, widowed, married, divorced 2 widowed

6. (b) Name of husband or wife Richard Nolpe Deid

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 6 1855
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 9 1948 to Oct 9 1948 that I last saw her alive on Oct 9 1948 and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE: Years Months Days If less than one day

86 10 3 _____ hr. _____ min.

General Emaciation

Chronic Nephritis

Pyosepticemic

Other conditions _____
(Include pregnancy within 3 months of death)

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

10. Usual occupation Housewife

Major findings: Of operations _____

Of autopsy 12/18

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name Morgan Cornelius

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

14. Maiden name Mary Ann Miller

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

16. (a) Informant Cornelius Wolfe

(b) Address Kidder Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11-1948
(Month) (Day) (Year)

(c) Place: burial or cremation Kidder

18. (a) Signature of funeral director E. Turner

(b) Address Kidder Mo.

19. (a) Oct. 10-1948 (Date received local registrar) (b) L. W. Jackson (Registrar's signature)

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 A. L. Darway (M. D. or other) _____

Address Kidder Mo. Date signed 10-10-48

APR 12 1948

NOV 19 1957

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.....

G. S. Groves

Licensed Embalmer No. *2857*

P. O. Address. *Pattonburg 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, fact should be so stated above.