S. No. 2
M—9-4-41
v. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

34339

State File No.

FILED NOV 10 1943

Registration District No. 1

Primary Registration District No. 3008

Registrar's No. 356

14
1
2

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

1. PLACE OF DEATH:

(a) County Calloway.

(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
State Hosp. no. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days (Specify whether
In this community 9 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pemiscot. 14

(c) City or town Caruthersville 1
(If outside city or town limits, write "RURAL") 2

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Sarah Nichols

3. (b) If veteran, name war DK

3. (c) Social Security No. DK.

4. Sex Female

5. Color or race colored 3

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

6. (b) Name of husband or wife

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

7. Birth date of deceased DK (Month) (Day) (Year)

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

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

10. Usual occupation housework

11. Industry or business

FATHER
12. Name DK
13. Birthplace DK (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name DK
15. Birthplace DK (City, town, or county) 9 (State or foreign country)

16. (a) Informant County Clerk
(b) Address Caruthersville Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-29-43 (Month) (Day) (Year)
(c) Place: burial or cremation Columbia Mo

18. (a) Signature of funeral director J. O. Roberts
(b) Address Columbia Mo.

19. (a) 10-29-43 (Date received local registrar) (b) Josie Morsenkhoff (Registrar's signature)

1141

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 27
year 1943 hour 9 minute 50 P. M.

21. I hereby certify that I attended the deceased from Oct 25, 1942 to Oct 27, 1943
that I last saw her alive on Oct 27, 1942;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchial Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Generalized Arterio Sclerosis	
Chronic Myo Carditis	

Major findings:
Of operations
Of autopsy 93d

PHYSICIAN
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature R. P. Price (M. D. or other) MD
Address Fulton Mo Date signed 10/27/43

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.