

No. 2
1-441
17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3818
State File No. _____
Registrar's No. **903**

FILED NOV 24 1943
Registration District No. **128**

Primary Registration District No. **2000**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **SPRINGFIELD MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1819 N. ROBERSON
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **GREENE**
(c) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL")
(d) Street No. **1819 N. ROBERSON**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **3**
year **1943** m. hour **2** minute **45** P. M.

21. I hereby certify that I attended the deceased from **1-24-** 19**43** to **11-3-** 19**43**
that I last saw **her** alive on **6/20/** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Decomposing heart**
Myocarditis Chronic Duration **2 yrs**

Due to _____
Due to _____
Other conditions _____
(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? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **C. E. Feller** (M. D. or other)
Address **Springfield Mo** Date signed **11-4-43**

3. (a) PRINT FULL NAME **HILAH NICHOLS ASBURY**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **49-03-6283**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**

6. (b) Name of husband or wife **unk.** 6. (c) Age of husband or wife if alive **Dec.** years

7. Birth date of deceased **march 4 1880**
(Month) (Day) (Year)

8. AGE: Years **63** Months **7** Days **29**
If less than one day _____ hr. _____ min.

9. Birthplace **Long Lane MO. D**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business **In home**

12. Name **M. H. Nichols**

13. Birthplace **unk. Ill**
(City, town, or county) (State or foreign country)

14. Maiden name **Wm. J. Fine Regan**

15. Birthplace **unk. unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Clarence Witt**

(b) Address **SPRINGFIELD MO.**

17. (a) **Burial** (b) Date thereof **Nov 5-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn Cem. W. Whitingner & Co.**

18. (a) Signature of funeral director _____
(b) Address **SPRINGFIELD MO.**

19. (a) **11-4-43** (b) **C. W. Handley**
(Date received local registrar) (Registrar's Signature)

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

984

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.....

Max Rhodes

Licensed Embalmer No. *4071*

P. O. Address.....

Springfield

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.