

FILED FEB 23 1944  
Registration District No. 150

Primary Registration District No. 5572

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence Prairie, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jackson Co. Emery Hosp. 0  
(If not in hospital or institution, give street number or location)  
(d) Length of stay: In hospital or institution 7 Days  
(Specify whether years, months or days) 67 yrs.

3. (a) PRINT FULL NAME

Martin E. Nation

3. (b) If veteran, name war

3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Nellie B Nation 6. (c) Age of husband or wife if alive ✓ years 1875  
7. Birth date of deceased March 22 1875  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>9</u>	<u>9</u>	hr. _____ min. _____

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

10. Usual occupation Retired Farmer

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

MOTHER FATHER { 12. Name John Nation  
13. Birthplace Unknown Penn. 1  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Murray  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Virgil Nation

(b) Address R.R. # B Box 442 Indep Mo

17. (a) Burial (b) Date thereof FEB 9-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salem Cemetery

18. (a) Signature of funeral director George C. Carlson

(b) Address Independence, Mo.

19. (a) Feb. 2, 1944 (b) F. M. Schlicher  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48  
(c) City or town Rural 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.R. #3 - Box 442 - Indep Mo.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31  
year 1944 hour 11 minute 40 A. M.

21. I hereby certify that I attended the deceased from Jan 25 1944 to Jan 31 1944  
that I last saw him alive on Jan 31 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia with abscessed right lung

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 glass) (e) Means of injury 0

23. Signature F. M. Schlicher (M. D. or other) MD

Address Blue Springs, Mo Date signed 2/4/44

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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 *George E. Carson*

Licensed Embalmer No. *2246*

P. O. Address *Independence, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 7370Registration District No. 150Primary Registration District No. 5572

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

## 1. PLACE OF DEATH:

- (a) County Jackson  
 (b) City or town Rural Prairie Twp  
 (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 Mattie E. Nations

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

4. Sex
- m
5. Color or race
- w
6. (a) Single, widowed, married, divorced
- w

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if

7. Birth date of deceased
- May 22 1885
- 
- (Month) (Day) (Year)

8. AGE: Years
- 68
- Months
- 9
- Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace
- Mo.
- 
- (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 \_\_\_\_\_
- 
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- Jan
- year
- 1944
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 lung abscess rightlobar pneumonia

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
- F. W. Tuttle
- (M. D. or other)
- MD

Address Blue Springs Mo. Date signed \_\_\_\_\_

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

SUPPLEMENTARY

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

7370