

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 16 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28926

State File No.

Registration District No. 336

Primary Registration District No. 6131

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Shannon.

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

(c) Name of hospital or institution: Home Monteer Mo
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME William Alexander Nicholson

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 Mary E Nicholson 6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased February 15 1855
(Month) (Day) (Year)

8. AGE: Years 90 Months 5 Days 9 If less than one day hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER { 12. Name John Nicholson

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

14. Maiden name Mary

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

16. (a) Informant Arlus Nicholson

(b) Address Monteer Mo

17. (a) 7/31/44 (Burial, cremation, or other) (Date thereof) (Month) (Day) (Year)

(c) Place: burial or cremation July 27 1944

18. (a) Signature of funeral director John F Duncan

(b) Address 7111 View Mo

19. (a) 8-2-44 (Date received local registrar) (b) Frank Hyde M.D. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1944 Hour 4:15 P.M. minute _____ M. _____

21. I hereby certify that I attended the deceased from May 15
1944 to May 20 1944
that I last saw him alive on May 15 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration Sudden

Due to arteriosclerosis

Due to _____

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

Major findings: 83a1 PHYSICIAN _____
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? _____

(Specify type of place) _____ (e) Means of injury _____

23. Signature R. J. Davis (M. D. or other) _____
Address Berk Tree Mo Date signed 7/25-44

744

RECEIVED

District Health Officer No. 5,

District File Number

844-445

Date Filed

8-14-44

5-14-44

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

John J. Amear

Licensed Embalmer No.

2516

P. O. Address

17th Street 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.