

FILED DEC 7 1944 180

Primary Registration District No. 5673

Registrar's No.

1. PLACE OF DEATH:

(a) County Lincoln
 (b) City or town Rural Monroe
 (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) 1
 (d) Length of stay: In hospital or institution _____
 In this community In This Community
 years, months or days 77

3. (a) PRINT FULL NAME MARGARET NICHOLS
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

4. Sex F 5. Color or race W
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 14 1866
 (Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days 19
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Homemaker

11. Industry or business _____

12. Name unknown

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 Mrs Robert Brown

(b) Address Ethlyn Mo.

17. (a) Burial (b) Date thereof Aug 5, 44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Prairie Cem

18. (a) Signature of funeral director Wayne Mc Coy

(b) Address Irving Mo.

19. (a) Aug 3 - 44 (b) Wm J. J. Allevato
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln
 (c) City or town _____
 (If outside city or town limits, write "RURAL") 570
 (d) Street No. _____
 (If rural, give location) 0
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3
 year 1944 hour 11 minute 55 M.

21. I hereby certify that I attended the deceased from July 26
 _____, 1944, to Aug 3, 1944
 and that I last saw her alive on Aug 2, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia of Right Lung, Lower Lobe.
 Duration _____

Due to _____

Due to _____

Other conditions Old age!
 (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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

23. Signature Wm J. J. Allevato (M. D. or D.O.)

Address Winfield, Mo. Date signed 8/5/44

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

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed..... 12-5-44

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.....

Wayne Mc Coy

Licensed Embalmer No. 3586

P. O. Address.....

Jroy 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. See

Registration District No. 180

Primary Registration District No. 5673

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Rural Monroeville
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lincoln

(c) City or town Esthler, Mo. - Rural
(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 _____

3. (a) PRINT FULL NAME Margaret Nichols

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

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 alive _____ years

7. Birth date of deceased mo 14 1866
(Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

38230