

FILED FEB 10 1945  
Registration District No. 21

Primary Registration District No. 3005

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

1. PLACE OF DEATH:

(a) County BATES

(b) City or town BUTLER  
(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 years, months or days)

In this community 2 MONTHS / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BATES

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

(d) Street No. 106 S MAIN  
(If rural, give location)

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

3. (a) PRINT FULL NAME JAMES W. NUCKOLS

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 2ND  
year 1945 hour 8 minute 15 P. M.

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife FLO NUCKOLS 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased APRIL 21-1892  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct. 1 44, 1944, to Jan. 2, 45, 1945;  
that I last saw him alive on Jan. 1, 45, 1945,  
and that death occurred on the date and hour stated above.

8. AGE: Years 72 Months 8 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death  
Cerebral Haemorrhage

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace MO (City, town, or county) \_\_\_\_\_ (State or foreign country) 0

10. Usual occupation RETIRED FARMER

Other conditions (Include pregnancy within 3 months of death) g. 30

Major findings: Of operations \_\_\_\_\_

Of autopsy None

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

12. Name JAMES NUCKOLS

13. Birthplace KY (City, town, or county) \_\_\_\_\_ (State or foreign country) 1

14. Maiden name VERLINDA

15. Birthplace KY (City, town, or county) \_\_\_\_\_ (State or foreign country) 1

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Flo Nuckols

(b) Address S Main - Butler

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-4-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Opshill

18. (a) Signature of funeral director W. Underwood

(b) Address Butler Mo

19. (a) 1-5-45 (Date received local registrar) (b) Furline Compton (Registrar's signature)

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 name of place) Means of injury 0

23. Signature C. M. P. P. P. (M. D. or other) \_\_\_\_\_  
Address Butler Mo. Date signed Jan 5, 45

MAR 4 1959

1-45-101  
2-9-45

**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 Glendon*

Licensed Embalmer No. *3585*

P. O. Address *Butler 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.**