

FILED NOV 8 1945

Registration District No. 324

Primary Registration District No. 372

Registrar's No. 152

1. PLACE OF DEATH: Saline

(a) County: Saline

(b) City or town: Marshall

(c) Name of hospital or institution: Fitzgibbons hospital

(d) Length of stay: In hospital or institution: 3 days

In this community: 14 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Saline 97

(c) City or town: Slater--Mo. (If outside city or town limits, write "RURAL") 2

(d) Street No.: (If rural, give location) 1

(e) Citizen of foreign country? yes (Yes or No) 0

If yes, name country:

3. (a) PRINT FULL NAME: Ira Nix

(b) If veteran, name war: no

(c) Social Security No.: none

4. Sex: male (1) Color or race: white

5. Color or race: white

6. (a) Single, widowed, married, divorced: married

6. (c) Age of husband or wife if alive: 59 years

7. Birth date of deceased: Sent. 5 1888

8. AGE: Years 62 Months 1 Days 12

If less than one day: hr. min.

9. Birthplace: Chariton County Mo. 0

(City, town, or county) (State or foreign country)

10. Usual occupation: produce dealer

11. Industry or business:

12. Name: G. W. Nix

13. Birthplace: Ky. 1

(City, town, or county) (State or foreign country)

14. Maiden name: Susan Latham

15. Birthplace: Mo. 0

(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Ira Nix

(b) Address: Slater, Mo.

17. (a) (b) Date thereof: 10-18-45

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Slater--Mo.

18. (a) Signature of funeral director: Hill Brothers

(b) Address: Slater--Mo.

19. (a) 10-17-45 (b) J. O. C. [Signature]

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. 17

1945 year. 4 hour. a minute.

21. I hereby certify that I attended the deceased from Sept. 4, 1945, to Oct. 16, 1945, that I last saw him alive on Oct. 16 - 45, and that death occurred on the date and hour stated above.

Immediate cause of death: Capillary Bronchial Pneumonia

Due to: Bronchitis with other type T.

Other conditions: none

(Include pregnancy within 3 months of death)

Major findings: none

Of operations: none

Of autopsy: none

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): none

(b) Date of occurrence: none

(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?

23. Signature: J. O. C. [Signature] (M. D. or other)

Address: Slater, Mo. Date signed: 10/17/45

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

MOTHER FATHER

7
2

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 11-8-75

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 Sam M Hill

Licensed Embalmer No. Slater 1292

P. O. Address Slater 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.