DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31029

FILED OCT 7 1946 A. Reeder

Registration District No. 9 2 8 Primary Registration District No. 5 8 2 1 Registrar's No.

1. PLACE OF DEATH:

(a) County: New Madrid

(b) City or town: Rural
(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 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid 72

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. 3 miles East of Matthews 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Clarence Nunn Jr

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex M 2

5. Color or race C

6. (a) Single, widowed, married, divorced S 0

6. (b) Name of husband or wife

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

7. Birth date of deceased 8 (Month) 1 (Day) 1944 (Year)

8. AGE: Years	Months	Days	If less than one day
2	1	3	hr. min.

9. Birthplace Matthews (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Clarence Nunn Sr.

13. Birthplace Humbolt (City, town, or county) Tenn. (State or foreign country) /

14. Maiden name Lula Simmons

15. Birthplace Bells (City, town, or county) Tenn. (State or foreign country) /

16. (a) Informant Clarence Nunn Sr.

(b) Address Matthews, Mo. R.F.D # 2 Box 143

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/46 (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director H.W. Albritton

(b) Address Sikeston, Mo.

19. (a) 10-9-46 (Date received local registrar) (b) Helen L. Jones (Registrar's signature)

216

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 4 year 1946 hour 4 minute 35 P.M.

21. I hereby certify that I attended the deceased from Only Sept., Ist., 19 46 to 19 ; that I last saw him alive on Sept., Ist., 46 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Rachitis	
Due to	
Due to Malnutrition & vitimin deficiency	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations 70

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature A. A. Ruter (M. D. or other)

Address Portageville, Mo. Date signed Sept., 16, 46

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 1046-11
Date Filed 10-3-46

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 Allerton

Licensed Embalmer No. 2941

P. O. Address Sulphur

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. ____

Registration District No. 238 Primary Registration District No. 5821 Registrar's No. 170

1. PLACE OF DEATH:

(a) County: New Madrid

(b) City or town: Rural
(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 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: New Madrid

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

(d) Street No.: 3 mi E of Matthews
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME: Clarence Nunn Jr.

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

4. Sex: M 5. Color or race: B 6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: Aug (Month) ____ (Day) ____ (Year)

8. AGE: Years 2 Months 1 Days 3 If less than one day: ____ hr. ____ min.

9. Birthplace: ____ (City, town, or county) Mo (State or foreign country)

10. Usual occupation ____

11. Industry or business ____

FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)

MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)

16. (a) Informant ____
(b) Address ____

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____
(b) Address ____

19. (a) 10-9-46 (Date received local registrar) (b) Helen Rowe Jordan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. year 1946 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.

	Duration
Immediate cause of death ____	
Due to ____	
Due to ____	
Other conditions (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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature ____ (M.D. or other) ____
Address ____ Date signed ____

SUPPLEMENTARY

31029