

S. No. 2
M-5-43
v. 5-17-39
p. 1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 15 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Turner
State File No. 27386
Registrar's No. 723

Registration District No. 128 Primary Registration District No. 2000

39
2
6

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

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution: 601 Normal
(d) Length of stay: 66 Years
In this community 66 Years

3. (a) PRINT FULL NAME Michael P. Nibler
3. (b) If veteran, name war No
3. (c) Social Security No. No.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Margaret Nibler
6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased October 6 1880

8. AGE: Years 66 Months 10 Days 11
If less than one day, hr. min.

9. Birthplace Springfield Missouri

10. Usual occupation _____

11. Industry or business Nibler Insurance Agency

MOTHER FATHER

12. Name John Nibler
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

16. (a) Informant Ralph Nibler
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 8/19/47
(c) Place: burial or cremation St. Mary Cemetery

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 8-25-47 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(d) Street No. 601 Normal
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 17
year 1947 hour 7 minute 30a. M.
21. I hereby certify that I attended the deceased from July 5, 1947
to August 17, 1947
that I last saw him alive on August 16, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis with right hemiplegia
Due to arteriosclerosis, general, and hypertensive and arterio-sclerotic heart disease.
Duration 6 wks.

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

Major findings: 975
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(c) Means of injury 0
23. Signature Dr. Turner (M. D. or other) _____
Address Med. Bldg. Spfld. Date signed Aug 22 1947

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.....

Paul G. Schuyler

Licensed Embalmer No. *2457*

P. O. Address *Shrewsbury, Mass*

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.