

No. 2  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

38546  
State File No.

Registration District No. 211

Primary Registration District No. 5291

Registrar's No. 10

1. PLACE OF DEATH: **COLE county**

(a) City or town: **Rural, Marion**

(b) State or town: **Missouri** (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: **72 yrs** (Specify whether years, months or days) **2**

In this community: **2** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **Cole**

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

(d) Street No.: **Near Marion, Mo.** (If rural, give location)

(e) If foreign born, how long in U. S. A.? **0** years.

3. (a) PRINT FULL NAME: **Viola W Nevins**

3. (b) If veteran, name war:

3. (c) Social Security No.: **NO**

4. Sex: **Female**

5. Color or race: **White**

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

6. (b) Name of husband or wife: **Mart Nevins**

6. (c) Age of husband or wife if alive: **22** years (Year) **1889**

7. Birth date of deceased: (Month) **Sept** (Day) **22** (Year) **1889**

8. AGE:

Years	Months	Days	If less than one day
<b>72</b>	<b>2</b>	<b>8</b>	hr. / min.

9. Birthplace: **Boon County** (State or foreign country) **S**

10. Usual occupation: **House wife**

11. Industry or business:

MOTHER FATHER { 12. Name: **Hugh Murphy**

13. Birthplace: **Virginia** (State or foreign country) **1**

14. Maiden name: **Harriet A. Murphy** (State or foreign country)

15. Birthplace: **Maryland** (City, town, or county) (State or foreign country) **1**

16. (a) Informant: **Edna Thompson**

(b) Address: **Marion, Mo.**

17. (a) (Burial, cremation, or removal) **burial** (b) Date thereof: **Dec 2 1940** (Month) (Day) (Year)

(c) Place: burial or cremation: **New Hope Cemt**

18. (a) Signature of funeral director: **Bowlin Funeral Home**

(b) Address: **California, Mo.**

19. (a) **Dec. 2-1940** (Date received local registrar) (b) **H. T. Lesch, M. D.** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **30** year **1940** hour **6** minute **-** M.

21. I hereby certify that I attended the deceased from **11-30** 19**40** and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic nephritis**

Due to:

Due to:

Other conditions: **1/21** (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? **191** (Specify type of place) (e) Means of injury:

23. Signature: **Edna Thompson** (M. D. or other) **Edna**

Address: **Marion, Mo.** Date signed: **12-27-40**

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

RECEIVED 11-30-40

STATE OF ILLINOIS  
DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS

**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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38546

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 211

Primary Registration District No. 5291

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Cole  
 (b) City or town Marion T.P.  
(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)

3. (a) PRINT FULL NAME Viola W. Nevins

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 m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years 72 Months 2 Days 8 If less than one day \_\_\_\_\_ min.

9. Birthplace Marion Cole County, Missouri  
(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 (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Dec 2-1940 (b) H. F. Leach, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 30  
 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h. \_\_\_\_\_ 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)

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

Duration

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

23. Signature A. L. Meredith (M.D. or other)

Address Prairie Home Date signed \_\_\_\_\_

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

SUPPLEMENTARY

