N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County DeKalb

Township Cultor

or Village

or City (NO. St.: Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 260 File No. 37579

Primary Registration District No. 5362 Registered No. 29

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Kenny E. Nichols

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE / MARRIED / WIDOWED / OR DIVORCED (Write the word)
Male	White	Widowed

DATE OF BIRTH March (Month) 12 (Day) 1848 (Year)

AGE 61 yrs. 9 mos. ds. | If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farming

BIRTHPLACE (City or town, State or foreign country) Mass.

PARENTS

NAME OF FATHER Sylvanus H. Nichols

BIRTHPLACE OF FATHER (City or town, State or foreign country) Richmond Mass

MAIDEN NAME OF MOTHER Mary Ann Cogswell

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Richmond Mass

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E. Scarlott

(ADDRESS) Osborn Mo.

Filed Dec 24, 1910. W. L. Slate REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. (Month) 9 (Day), 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec —, 19—, to Dec 9, 1910, that I last saw h[illegible] alive on Dec 8, 1910, and that death occurred, on the date stated above, at 12:45 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

4 M.

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) 9 yrs. mos. ds.

(Signed) W. E. Clark M. D.

Dec 12, 1910. (Address) Maysville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Amity Mo	Dec 10, 1910

UNDERTAKER	ADDRESS
Geo W. Howell	Amity Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory. The* material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer. Laborer—Coal mine* etc. *Woolen*

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia,*" "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMI-CIDAL, or as *probably* such if impossible to determine

MISS

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....

Registration District No.....

Primary Registration District No.....

(NO.....)

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write* the word)

DATE OF BIRTH ....., 1..... (Month) (Day) (Year)

AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country) .....

PARENTS

NAME OF FATHER .....

BIRTHPLACE OF FATHER (City or town, State or foreign country) .....

MAIDEN NAME OF MOTHER .....

BIRTHPLACE OF MOTHER (City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191.....

REGISTRAR

MI.....

DATE OF DEATH .....

I HER.....

.....that I last saw h.....

and that death.....

The CAUSE OF .....

.....

.....

.....

Contributory (SECONDARY) .....

(Signed) .....

*State the Disease (1) Means of Injury; a

LENGTH OF RESIDENCE (In case of RECENT RESIDENTS):
At place of death ..... yrs.
Where was disease contracted, if not at place of death?
Former or usual residence.....

PLACE OF BURIAL

UNDERTAKER