

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

PLACE OF DEATH
County Lumpkin

Township _____
or
Village _____
or
City Chillicothe (NO. _____)

Registration District No. 508

File No. 20613

Primary Registration District No. 3026

Registered No. 72

(NO. St. Mary's Hospital St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME James E. Nichols

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED married but WIDOWED not living with OR DIVORCED wife (Write the word)

DATE OF BIRTH Don't know (Month) _____ (Day) _____ (Year) _____

AGE 51 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Grundy Co. Mo.

PARENTS NAME OF FATHER Wm Nichols BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio MAIDEN NAME OF MOTHER Hafner BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) John H. Wilson (ADDRESS) Wheeling Mo.

Filed June 20 1912 REGISTRAR R. Barney

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 19, 1912 (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from June 16, 1912, to June 19, 1912, that I last saw him alive on June 19, 1912,

and that death occurred, on the date stated above, at 1 P.m.

The CAUSE OF DEATH* was as follows: Interstitial Nephritis

(Duration) One yrs. _____ mos. _____ ds.

Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Ruebeck Barney M. D. (Address) Chillicothe 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 _____ yrs. _____ mos. _____ ds. State 51 yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____

Former or usual residence Lewings ton Co. Mo.

PLACE OF BURIAL OR REMOVAL Wheeling Cemetery DATE OF BURIAL June 20, 1912

UNDERTAKER J. Mohr & Son ADDRESS Chillicothe Mo.

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

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____ (NO. _____)

Registration District No. _____
 Primary Registration District No. _____

File No. _____
 Registered No. _____

St. _____ Ward _____
 [If death occurred in hospital or institution give its NAME inside of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
COLOR OR RACE	
DATE OF BIRTH	(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) _____

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 _____

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

MEDICAL CERTIFICATE OF DEATH
 DATE OF DEATH _____ (Month) _____ (Day) _____, 191____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____
 The CAUSE OF DEATH* was as follows:

Contributory
 (SECONDARY)
 (Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Address) _____ M. D. _____

*State the Disease Causing Death or, in deaths from Violent Cause, 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 _____ 191____
UNDERTAKER _____
ADDRESS _____

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH
 Form No. 1 (Revised 1918)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH
County Livingston

Township _____

Village _____

City Chillicothe

Registration District No. 578

Primary Registration District No. 3026

(No. St. Mary's Hospital)

File No. 20613

Registered No. 72

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

FULL NAME

James E. Nichols

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Don't know
(Month) (Day) (Year)

AGE 57 yrs. _____ mos. _____ ds.
IF LESS than 1 day, _____ hrs. _____ or _____ min.

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

BIRTHPLACE (City or town, State or foreign country) Grundy Co. Mo.

PARENTS NAME OF FATHER Wm Nichols
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER (Not known) Haplin
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John H. Wilson

(ADDRESS) Wheeling, Mo.

Filed June 20 1912 R Barney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 19, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 16, 1912, to June 19, 1912
that I last saw him alive on June 19, 1912
and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:
Interstitial nephritis
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Reuben Barney M. D.
June 19, 1912 (Address) Chillicothe 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 Wheeling Cem. DATE OF BURIAL June 20, 1912

UNDERTAKER J. Mohr & Son ADDRESS Chillicothe Mo.

RECORDED

N. B. - Ever it is inform on the d be carefully supplied. After should be stated EXACTLY. PHYSICIANS should state the cause of death in terms of properly classified. Exact statement of OCCUPATION is very important.

SUPERSEDED

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*, *Composer*, *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. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

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 septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)