

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

Do not use this space.

27799

1. PLACE OF DEATH

County Marion Registration District No. 547
Township Marion Primary Registration District No. 2029
City Hannibal (No. Leveering Hospital)

File No. _____
Registered No. 262
St. _____ Ward _____

2. FULL NAME

Lula Elizabeth Nichols
(a) Residence. No. Center Ralls Co mo. Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF L. A. Nichols

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 25 1899

7. AGE YEARS MONTHS DAYS IF LESS than day, hrs. or min.
32 6 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ralls Co mo

10. NAME OF FATHER L. B. Hamilton

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ind

12. MAIDEN NAME OF MOTHER Alice Kimball

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ind

14. INFORMANT Bellevue A Nichols
(Address) Center mo

15. FILED 9/27 27 C. E. Stoll
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 25 1927

17. I HEREBY CERTIFY, That I attended deceased from 9-16-27, 1927, to 9-25-, 1927, that I last saw him alive on 9-25-, 1927, and that death occurred, on the date stated above, at 10:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Appendicitis
171 B / 1770
CONTRIBUTORY (SECONDARY) _____
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF 9-16-27

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) W. P. Birney, M. D.

(Address) Hannibal mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Pleasant Grove DATE OF BURIAL Sept 27 1927
20. UNDERTAKER Wm. M. Smith ADDRESS Hannibal

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.

