

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

Do not use this space.

38082

1. PLACE OF DEATH

County St. Louis Registration District No. 790 File No. _____
 Township Gratwick # Primary Registration District No. 6033 Registered No. _____
 City St. Louis (No. 6410 San Bonita) St. _____ Ward _____

2. FULL NAME

William Alexander Nicholson

(a) Residence. No. 6410 San Bonita Ward. _____ (If nonresident give city or town and State)
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1 - 1836

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
92 | 10 | 21 | 2 hrs. 0 min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Carpet Manager
 (b) General nature of industry, business, or establishment in which employed (or employer) Remards
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Baltimore
 (STATE OR COUNTRY) Maryland

10. NAME OF FATHER William Nicholson

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

12. MAIDEN NAME OF MOTHER Elizabeth Fowler

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

14. INFORMANT W. A. Nicholson Jr.
 (Address) 6410 San Bonita

15. FILED Nov 28 1928 Katharine W. Sullivan
 REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 22nd 1928

I HEREBY CERTIFY, That I attended deceased from Nov 15 1928, to Nov 22 1928, that I last saw him alive on Nov 22 1928, and that death occurred, on the date stated above, at 10:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

186A Intracapsular fracture of femur
194B (duration) yrs. mos. 7 ds.
104A Pneumonia
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

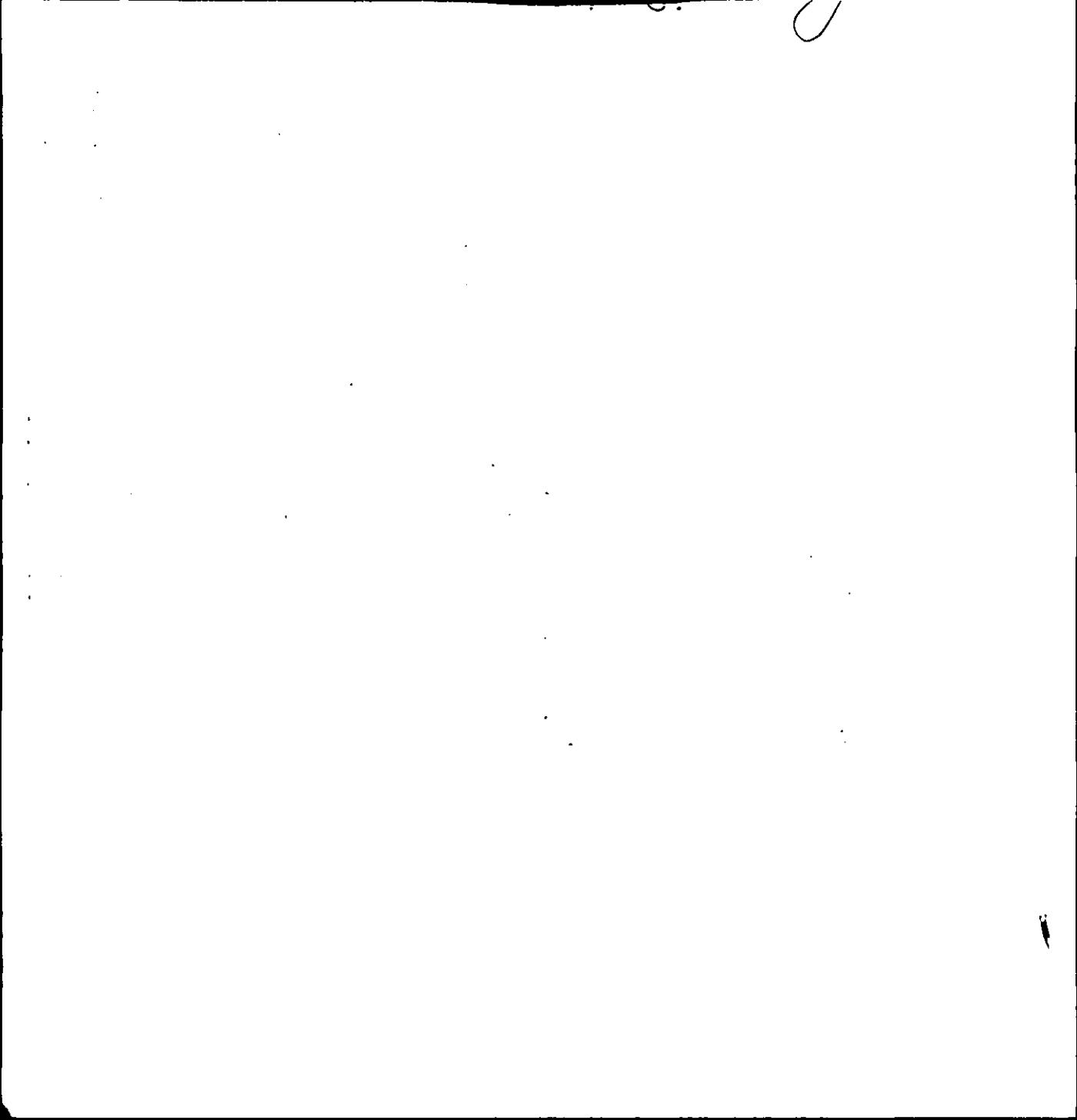
19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) W. H. Muddlach, M. D.
11/23, 1928 (Address) 1001 No. Bldg.

*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 Bellefontaine DATE OF BURIAL Nov 24th 1928

20. UNDERTAKER C. R. Lupton ADDRESS 4449 Olive St.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 790 File No.
Township Clayton Primary Registration District No. 6033 Registered No.
City (No.) St. Ward)

2. FULL NAME

William Alexander Nicholson

(a) Residence No. St. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 11-23-28 Katherine W. Dullerach REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 22 1928

17. I HEREBY CERTIFY, That I attended deceased from to 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

fracture of femur
stepped on floor in getting
up from chair (duration) yrs. mos. ds.
CONTRIBUTORY pneumonia (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dundelach M.D. , 19 (Address)

*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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY

S-38082