

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

28589

Do not use this space.

REC'D SEP 12 1939

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 1
 (b) Township St Joseph Primary Registration District No. 355 Registered No. 817
 (c) City St Joseph (d) Street No. St Joseph Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 2422 James Ray Nichols St. Gallatin Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>✓</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept. 13-1938</u>		
7. AGE	YEARS <u>0</u>	MONTHS <u>10</u>
		DAYS <u>24</u>
		If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>none</u>	11. Total time (years) spent in this occupation <u>✓</u>
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>✓</u>	
	10. Date deceased last worked at this occupation (month and year) <u>✓</u>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Davess Co. Missouri</u>		
FATHER	13. NAME <u>James E. Nichols</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Davess Co. Missouri</u>	
MOTHER	15. MAIDEN NAME <u>Fern Carter</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Davess Co. Missouri</u>	
17. INFORMANT (ADDRESS) <u>James E. Nichols</u> <u>Gallatin Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE <u>Gallatin Mo</u> <u>Aug. 8</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Hope Fern. F. Hub. Co.</u> <u>Gallatin Mo.</u>		
20. FILED <u>Aug 7 1939</u> <u>H. Nestle</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 7, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 13 - 1939, to Aug 7 1939
 I last saw him alive on Aug 6 1939. Death is said to have occurred on the date stated above, at 5 A. m.
 The principal cause of death and related causes of importance were as follows:
Intestinal obstruction -
Caused by intussusception
 Other contributory causes of importance:
Swallowing of safety pin (open)
 Name of operation Exploratory + enterotomy Date of 7-13-39
 What test confirmed diagnosis? X-ray, t.p.a. Was there an autopsy? No
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? acc Date of injury 7-13 1939
 Where did injury occur? Swallowed pin at home
 (Specify city or town, county, and State) Gallatin Mo
 Specify whether injury occurred in Industry, in home, or in public place.
 Manner of injury Swallowed pin
 Nature of injury
 24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify
 (Signed) Paul Ferguson, M. D.
 (Address) St Joseph, Mo

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.

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.....

L. O. Richesson

Registered Apprentice No.

working under my personal supervision.

Signed *L. O. Richesson*

Licensed Embalmer No. *3302*

P. O. Address *Galveston, M.*

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

If this body is not embalmed, above space should be left blank.