

Registration District No. **397**

Primary Registration District No. **1002**

Registrar's No. **3851**

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Kansas City**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **1100 Sun Hosp**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7 days**
 In this community **14 years**
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MO** (b) County **Jackson**
 (c) City or town **Kansas City**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **1014 Washington**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

8. (a) PRINT FULL NAME **Bonnie Nichols**
8. (b) If veteran, name war **no** **8. (c) Social Security No.** **no**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **2**
 year **1939** hour **12** minutes **P.M.**

4. Sex **F** **5. Color or race** **W** **6. (a) Single, widowed, married, divorced** **D.**
6. (b) Name of husband or wife **Unkn** **6. (c) Age of husband or wife if living** _____ years
7. Birth date of deceased **June 17 - 1909**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept 25 - 1939** to **Oct 2 - 1939**
 that I last saw her alive on **Oct 2 - 1939**
 and that death occurred on the date and hour stated above.

8. AGE: Years **30** Months **3** Days **20**
 If less than one day _____ hr. _____ min.

Immediate cause of death _____ Duration _____
Postoperative Peritonitis
 Due to **Intestinal obstruction**
 Due to **Old Pelvic Adhesions**
 Other conditions **1939**
 (Includes pregnancy within 3 months of death)

9. Birthplace **Oklahoma**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Waitress**
11. Industry or business
12. Name **Wm Nichols**
13. Birthplace **MO**
 (City, town, or county) (State or foreign country)
14. Maiden name **Nicola Brasler**
15. Birthplace **Little Rock Ark**
 (City, town, or county) (State or foreign country)

Major findings: **See above**
 Of operations **See above**
 Of autopsy **See above**
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature **Richard Clark**
(b) Address **1100 Sun Hosp**
17. (a) Removal **(b) Date thereof** **10 5 1939**
 (Date, location, or cause) (Month) (Day) (Year)
(c) Place: burial or cremation **Waffle Hill K.C. Kas**
18. (a) Signature of funeral director **Th. F. Grayson**
(b) Address **15 E. Grand**
19. (a) 10-5-39 **(b) M. M. Crowe**
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
 While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **P. F. De Maria** (M.D. or other) _____
Address **Supt 1100 Sun Hosp** Date signed _____

I X1931
 WHILE I REMAINLY USE CONTINUING BLACK INK-MAKE A PERMANENT RECORD
 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.....

R. E. Snow

Emb
Registered Apprentice No. *2560*

working under my personal supervision.

Signed

W. J. Mayberry

Licensed Embalmer No. *2934*

P. O. Address.....

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.