

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.

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

35650  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Callaway 3 Registration District No. 104  
 (b) Township 1 Primary Registration District No. 3028  
 (c) City Fulton or (d) Street No. State Hospital #1 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. 2 mos. 29 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Robert Nichols  
 (a) Residence, No. Columbia Mo St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (S)  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 7th 1863  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
76 76 2 13  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. Labour  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DK  
 FATHER 13. NAME Geo. Nichols  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DK  
 MOTHER 15. MAIDEN NAME DK  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DK  
 17. INFORMANT (ADDRESS) State Hospital #1 Nichols Fulton Mo  
 18. BURIAL, CREMATION, OR REMOVAL PLACE New Providence DATE 10-23 39  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Parker F. Rhoads Columbia Mo  
 20. FILED Oct 21, 1939 R. N. Crews Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 20th 1939  
 22. I HEREBY CERTIFY, That I attended deceased from July 22nd 1939 Oct. 20 1939  
 I last saw him alive on Oct. 20 1939. Death is said to have occurred on the date stated above, at 9:38 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Arteriosclerosis  
97  
 Other contributory causes of importance:  
Dehydration  
Senile Psychosis  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? No Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_  
 (Signed) Mrs. J. Wood, M. D.  
109 (Address) State Hwy. #1 Fulton, Mo.

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.**