

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.

Registration District No. 47

Primary Registration District No. 5081

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Bates

(b) City or town Near Adrian  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community Life Time years, months or days

3. (a) PRINT FULL NAME Edgar E. Nichol

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Widow

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec. 4 1875  
(Month) (Day) (Year)

8. AGE: Years 64 Months 0 Days 1 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Bates County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Lucian Nichol

18. Birthplace Wells County Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Gage

15. Birthplace Bluffton Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Arnie Nichol

(b) Address Adrian Mo. #4

17. (a) Burial (b) Date thereof Dec 7-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hill Cem.

18. (a) Signature of funeral director Leath & Dix

(b) Address Adrian Mo. 56

19. (a) Dec 10-1939 (b) Ethel C. Stephens  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. East Boone Swb.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5th day Dec., year 1939 hour 1:30 minute P.M.

21. I hereby certify that I attended the deceased from Dec. 5, 1939 to Dec. 5, 1939

that I last saw him alive on Dec. 5, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Cerebral apoplexy

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) HTA

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) none

(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? \_\_\_\_\_

(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury 1

23. Signature E. E. Robinson (M. D. or other) M.D.

Address Adrian Mo. Date signed 12-6-39

FEB 11 1950

RECEIVED

District Health Officer No. 7,  
District File Number 1-9-40  
Date Filed 1-9-40

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 any

Fred J. Creaath, M.C. # 3343, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 3650

P. O. Address Adrian Mo

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.