

No. 2
1-10-39
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X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24565**

Registration District No. **73**

Primary Registration District No. **3006**

Registrar's No. **161**

I. PLACE OF DEATH

(a) County **Boone**
(b) City or town **Columbia**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Ellis Fischel State Cancer Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **14 dds**
(Specify whether
In this community _____
years, months or days)

8. (a) PRINT FULL NAME **Mrs. Sarah Ellen Nicholson**

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Sept 8 1869**
(Month) (Day) (Year)

8. AGE: Years **70** Months **10** Days **23** If less than one day _____ hr. _____ min.

9. Birthplace **Crawford County Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business **Housework**

12. Name **Thomas Nicholson D.**

13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret Ziegler**

15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Social Service Record**

(b) Address **Ellis Fischel State Cancer Hosp.**

17. (a) **Removed** (b) Date thereof **Aug 3-4 8**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Astoria Mo**

18. (a) Signature of funeral director **Gene E. Haldren**

(b) Address **Hartsville Mo**

19. (a) **8/1/40** (b) **Allie Selby**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Crawford**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Star Route, Embree, Mo**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **31st**
year **1990** hour **11:00** minute **50 AM.**

21. I hereby certify that I attended the deceased from **July 19th 1990**, to **July 31st 1990**
that I last saw her alive on **July 31st 1990**
and that death occurred on the date and hour stated above.

Immediate cause of death
① Carcinoma of lower lip Duration **7 yrs**

Due to **② Respiratory pneumonia** **3 days**

Due to _____
Other conditions **45**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **none**
Of autopsy **none**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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? **74**
(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature **E.E. Royce** (M. D. or other) **1**
Address **Ellis Fischel State Cancer Hosp.** Date signed **7/31/90**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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 Gene E. Holden
Licensed Embalmer No. 3865
P. O. Address Hartsville, Md.

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.