

ED NOV 12 1943

Registration District No. 334 Primary Registration District No. 3072

1. PLACE OF DEATH:

(a) County Saline

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

(c) Name of hospital or institution: Fitzgibbon Hospital  
(If not a hospital or institution, write street number or location)

(d) Length of stay: 2 weeks  
(Specify whether in hospital or institution)

In this community 23 4 years  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo County Saline

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lerosa Nichols

3. (b) If veteran,  name war \_\_\_\_\_

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 21  
year 1943 hour 1 minute 29 M.

21. I hereby certify that I attended the deceased from Oct 3 to Oct 21  
that I last saw her alive on Oct 21 and that death occurred on the date and hour stated above.

4. Sex male 5. Color of Black (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Coreale Nichols 6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased Oct 16 - 1904  
(Month) (Day) (Year)

Immediate cause of death: Cerebral Thrombosis  
pneumonia

Due to Cerebral Thrombosis 12 day following stroke

Due to Stroke 21 day

Other conditions (including pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 39 Months 0 Days 5 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace New Frankfurt, Saline Co, Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Railroad Section Chief

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

12. Name Joseph Nichols

13. Birthplace Centerville, Saline Co, Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Harriet Jennings

15. Birthplace Slater, Saline Co, Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Francis Nichols

(b) Address Slater, Mo

17. (a) Removal ✓ (b) Date thereof 10-24-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's, Slater, Mo

18. (a) Signature of funeral director James R. Barger

(b) Address Slater, Mo

19. (a) 10-24-43 (b) Mrs T. O. Westhead  
(Date received local registrar) (Registrar's signature)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: none

Of operations none

Of autopsy none

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? none

While at work? ✓ (Specify type of place) \_\_\_\_\_

(e) Means of injury \_\_\_\_\_

Signature W. E. Lathrop (M. D. or other) \_\_\_\_\_

Address Slater, Mo Date signed 10/24/43

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

MOTHER FATHER

JAN 12 1949

RECEIVED

Health Officer No. 8,

State File Number \_\_\_\_\_

Date Filed 11-10-43

APR 8 1949

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 \_\_\_\_\_

working under my personal supervision. \_\_\_\_\_ Registered Apprentice No. \_\_\_\_\_

Signed James Jones

Licensed Embalmer No. 3146

P. O. Address State 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, fact should be so stated above.