

FILED APR 10 1944  
128

Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County GREENE  
 (b) City or town Springfield  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 513 E. MONROE ST.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME LEOTA ELLIS NICHOLS  
 3. (b) If veteran, name war NONE  
 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced, SINGLE  
 6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive XX years  
 7. Birth date of deceased JUNE 15 1910  
 (Month) (Day) (Year)

8. AGE: Years 33 Months 9 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Springfield MO.  
 (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business at home (invalid)

12. Name Walter E. Nichols

13. Birthplace unk. MO.  
 (City, town, or county) (State or foreign country)

14. Maiden name Emma Matney

15. Birthplace unk. Unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant Lottie Moskowitz  
 (b) Address Springfield Mo.

17. (a) Burial (b) Date thereof Mar. 24 1944  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation maple Park Cem.

18. (a) Signature of general director J. W. Lingner Co.  
 (b) Address Springfield, Mo.

19. (a) 3-22-44 (b) 5-11-44  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. County Greene  
 (b) City or town Springfield  
 (If outside city or town limits, write "RURAL")  
 (c) Street No. 513 E. Monroe  
 (If rural, give location)  
 (d) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22  
 year 1944 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from 3, 22, 44 19 to 3, 22, 44 19  
 that I last saw h. er alive on 3, 22, 44 19  
 and that death occurred on the date and hour stated above.

Immediate cause of death Constipation, acute to almost complete abstruction  
 Due to Malformation, congenital. She has never walked, talked or been able to feed herself. Very feeble minded. Always been constipated.  
 Other conditions (Include pregnancy within 3 months of death)  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

PHYSICIAN 157 MM  
 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature J. D. Musick MD (M. D. or other) \_\_\_\_\_  
 Address Springfield, Mo. Date signed 3, 23, 44

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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.....

*Ogle Stone Jr.*

Licensed Embalmer No. *4176*

P. O. Address.....

*Springfield*

**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.**

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