. S. No. 2
M—8-
v. 5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 23 1944

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26936

Primary Registration District No. 1002

Registrar's No. 3294

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K.C. Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 623 Euclid 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yrs (Specify whether years, months or days)

In this community 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Mo. (If outside city or town limits, write "RURAL")

(d) Street No. 623 Euclid 3 (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mrs Permetia J. Nichols

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Fe 1

5. Color or race Wh

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

6. (b) Name of husband or wife James Nichols

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

7. Birth date of deceased April (Month) 19 (Day) 1866 (Year)

8. AGE: Years 78 Months 3 Days 20 If less than one day hr. min.

9. Birthplace (City, town, or county) mo 0 (State or foreign country)

10. Usual occupation at home

11. Industry or business

FATHER 12. Name Sidney Alberson

FATHER 13. Birthplace Ky. 1 (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Mary Schock

MOTHER 15. Birthplace Mo. 0 (City, town, or county) (State or foreign country)

16. (a) Informant Minnie A. Vaughn

(b) Address 3810 E 78 St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Mrs C.L. Forster

(b) Address 918-920 Brooklyn

19. (a) 8-10-44 (Date received local registrar) (b) N. C. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9th year 1944 hour 1 minute 20 P.M.

21. I hereby certify that I attended the deceased from June 22 1944 to August 9 1944 that I last saw her alive on August 9 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar Pneumonia	4 days
Due to	
Due to 108	
Other conditions (Include pregnancy within 3 months of death) Paralysis Agitans	10 yrs

Major findings:
Of operations
Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature G. L. Reed (M. D. or other) M.D.

Address 6323 Brookside Blvd Date signed 8-10-44

361 (Licensed Embalmer's Statement on Reverse Side)

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 Wm. H. Jackson

Licensed Embalmer No. 3254

P. O. Address Keene

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.