

V. S. No. 2  
100M-5-43  
Rev. 5-17-39  
I X36671

12391

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 1653

**FILED APR 25 1945**  
Registration District No. 149

Primary Registration District No. 1001

49  
83

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

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
2641 Forest  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution no  
(Specify whether  
 In this community 3 weeks  
years, months or days)

**3. (a) PRINT FULL NAME** George Henry Nichols  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. no

4. Sex Male 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 \_\_\_\_\_ years  
 7. Birth date of deceased 9/2/1860  
(Month) (Day) (Year)

**8. AGE:** Years 84 Months 7 Days 9  
 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

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

MOTHER FATHER

12. Name C. W. Nichols

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

14. Maiden name Sarah H. Nichols

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

16. (a) Informant Mrs. Ruth Hockaday

(b) Address Slater, Mo.

17. (a) Burial (b) Date thereof 4/13/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Slater, Mo.

18. (a) Signature of funeral director John P. Sheil

(b) Address Kansas City, Mo.

19. (a) 4-12-45 (b) Seraldine Holmes  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2641 Forest  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 11th  
 year 1945 hour 3 minute P.M.  
 21. I hereby certify that I attended the deceased from 3-20  
 \_\_\_\_\_, 1945, to 4-11, 1945  
 that I last saw him alive on April 10th, 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Old Age  
 Due to Senility

Due to \_\_\_\_\_  
 Other conditions 1626  
(Include pregnancy within 3 months of death)

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

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 W. L. Olor (M. D. or other) 200  
 Address 3-East 39th Date signed 4/13/45

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

Argile 12th + 14th

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.....

*John P. Sheel*

Licensed Embalmer No. 36257

P. O. Address. Kansas City 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, fact should be so stated above.