

FILED AUG 23 1945

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

Primary Registration District No. 3006

Registrar's No. 218

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Casper Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas  
(c) City or town Buffalo, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. Old Star Route  
(If rural, give location)  
(e) Citizen of foreign country? No  
If yes, name country None

3. (a) PRINT FULL NAME Nicholas, Lillie Ann

3. (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Nicholas J. D. 6. (c) Age of husband or wife if alive 80 years  
7. Birth date of deceased Aug 12 1945  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>72</u>	<u>11</u>	<u>3</u>		hr. min.

9. Birthplace Dallas Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Dallas Holland

13. Birthplace Dallas Co. Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Irene Strickland

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

16. (a) Informant Hospital Record

(b) Address Columbia Mo

17. (a) Burial (b) Date thereof: Aug 14 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buffalo Mo

18. (a) Signature of funeral director James Funeral Home

(b) Address Colum. Buffalo Mo

19. (a) 8-13-1945 (b) Edman H. Barber  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12  
year 1945 hour 11 minute 10 A.M.

21. I hereby certify that I attended the deceased from July 30 1945 to Aug 12 1945  
that I last saw him alive on Aug 12 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death abd. perneal resection rectum  
Duration \_\_\_\_\_

Due to Adenocarcinoma of rectum

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

Major findings: Of operations abd. perneal resection of rectum  
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? Jack Gilford (c) Means of injury \_\_\_\_\_

23. Signature Jack Gilford (M. D. or other)  
Address Ellis Chapel Star Care Hosp. Date signed 8/13/45

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

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RECEIVED

District Health Officer No. 9,

District File Number

Date Filed

8-22-45

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.....

Licensed Embalmer No.....

P. O. Address.....

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.