S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27649

Registration District No. 156 Primary Registration District No. 2001 Registrar's No.

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Johns Hospital 0
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County 999
(c) City or town Rural 10
(If outside city or town limits, write "RURAL")
(d) Street No. R. 4, Columbus 0
(If rural, give location)
(e) Citizen of foreign country? no 2 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ELMER-Curtis-Nicholson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex MALE 0
5. Color or race WHITE
6. (a) ~~Single, widowed,~~ married, ~~divorced~~ 1
6. (b) ~~Name of husband or~~ wife Lilah Rae Nicholson
6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased Oct 26 - ~~1~~ 1887 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
57	10	9	hr. min.

9. Birthplace Columbus Kansas 1 (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Clark Nicholson 1
13. Birthplace New York 1 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Alice A Rhodes
15. Birthplace New York 1 (City, town, or county) (State or foreign country)
16. (a) Informant Lilah Rae-Nicholson
(b) Address Columbus BR #4
17. (a) (Burial, ~~cremation, or removal~~) (b) Date thereof Aug 19-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Park Cemetery Columbus Kan.
18. (a) Signature of funeral director John D Hubland
(b) Address Columbus Kansas
19. (a) 8-23-45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17 year 1945 hour 8 a.m. minute M.
21. I hereby certify that I attended the deceased from 1-24-42, 19, to Aug 17-45, 19 that I last saw him alive on 8-17-45, 19 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Intestinal obstruction	12 hrs
Due to: Lipos carcoma +	8 months
Due to: metastases to mesentery	one month
Other conditions (Include pregnancy within 3 months of death) H6	

Major findings: Of operation Lipos carcoma 5-22-45
metastases to mesentery
~~Of autopsy~~ 8-7-45
with obstruction

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 0
23. Signature Walter [illegible] (M. D. or other)
Address Joplin Mo Date signed 8/21/45

1404

(Licensed Embalmer's Statement on Reverse Side)

45-8-688

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 F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin 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.