S. No. 2
M—5-42
v. 5-17-39
I X32873

Dr. Hamss

Call 919

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 17 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21743

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 99

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: St Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 1976 N. Johnson Avenue,
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Thomas Nicholson
3. (b) If veteran, name war None
3. (c) Social Security No. 491-03-0471
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mida Nicholson
6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased June (Month) 3, (Day) 1897 (Year)

8. AGE:	Years	Months	Days	If less than one day
✓	48	6	2	hr. min.

9. Birthplace Bartlesville (City, town, or county) Okla. (State or foreign country)
10. Usual occupation Meat Cutter
11. Industry or business Meat Cutting
FATHER
12. Name John Nicholson
13. Birthplace unk. (City, town, or county) Missouri. (State or foreign country)
MOTHER
14. Maiden name Neoma Capps,
15. Birthplace unk. (City, town, or county) Tenn. (State or foreign country)
16. (a) Informant Mida Nicholson
(b) Address 1976 N. Johnson, Springfield Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-45 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn
18. (a) Signature of funeral director W. Klingner Co
(b) Address Springfield, Mo.
19. (a) 12-7-45 (Date received local registrar) (b) O. W. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 5 year 1945 hour 6: minute 30 P.M.
21. I hereby certify that I attended the deceased from Dec. 5, 1945, to Dec. 5, 1945 that I last saw him alive on Dec. 5, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 hrs.
Due to Essential Hypertension	2½ yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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 C. W. Hamss (M. D. or other) M.D.
Address Med. Arts Bldg. Springfield, Mo. Date signed 12-6-45

(Licensed Embalmer's Statement on Reverse Side)

100144

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

JAN 16 1945 FEB 18 1945

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. 4070

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.