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DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
FILED JUL 24 1946 STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22707

State File No. _____

Registration District No. 34

Primary Registration District No. 5117

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Rural Cedar
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4 Miles West of Ashland, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community 4 1/2
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town 174701
(If outside city or town limits, write "RURAL")

(d) Street No. 4 Miles West of Ashland, Mo.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Herman Lee Nichols

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4
year 1946 hour 12 minute 10 A. M.

21. I hereby certify that I attended the deceased from Aug 1
1945 to July 4 1946
that I last saw him alive on July 4 1946
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Myra Bell Nichols

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased Sept 9 1889
(Month) (Day) (Year)

Immediate cause of death: Chronic nephritis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years 56 Months 9 Days 25
If less than one day hr. _____ min. _____

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

10. Usual occupation FARMER

Major findings: Of operations _____

Of autopsy _____

1318

MOTHER FATHER

11. Industry or business _____

12. Name James Addison Nichols

13. Birthplace Missouri 10
(City, town, or county) (State or foreign country)

14. Maiden name Mary Elley Mizie

15. Birthplace Missouri 10
(City, town, or county) (State or foreign country)

16. (a) Informant Myra Bell Nichols

(b) Address 747 S. 24th St. Ashland, Mo.

17. (a) B47101 (b) Date thereof 7-5-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gosper Cem.

18. (a) Signature of funeral director W. L. Burnett

(b) Address Ashland, Mo.

19. (a) 7-4-46 (b) Mrs. Mildred Burnett
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury

23. Signature H. B. Foy (M. D. or other) _____
Address Ashland Mo Date signed 7-7-46

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

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

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 1-23-46

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 Me

....., Registered Apprentice No.
working under my personal supervision.

Signed Wm C. Burnett

Licensed Embalmer No. 3568

P. O. Address Island, Md

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. AugRegistrar's No. 120Registration District No. 34Primary Registration District No. 5117

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days3. (a) PRINT FULL NAME Norman I. Nichol

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Sept 9 (Month) (Day) (Year)8: AGE: Years 56 Months _____ Day _____ (If less than one day) _____ hr. _____ min.9. Birthplace Missouri (City, town, or county) (State or foreign country)10. Usual occupation Sticker

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-4-46 (b) Mrs Mildred Burnett (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

22707