

FILED JUN 3 1947

State File No. _____

Registration District No. 387

Primary Registration District No. 5763

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution:
6 miles N.W. Tebbetts, Mo
(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 Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway

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

(d) Street No. 6 miles N. W. Tebbetts, Mo.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Nannie B. Nichols

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16
year 1947 hour 6 minute P.M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Garland Nichols

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

7. Birth date of deceased 12 30 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 16, 1947, to May 16, 1947
that I last saw him alive on May 16, 1947
and that death occurred on the date and hour stated above.

Duration _____

Immediate cause of death Cerebral Hemorrhage

8. AGE:

Years	Months	Days	If less than one day
<u>85</u>	<u>4</u>	<u>16</u>	hr. _____ min.

Due to _____

Due to _____

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

10. Usual occupation Housewife

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

11. Industry or business _____

12. Name Silas B. Davis

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

14. Maiden name Sallie ANN Davis

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

16. (a) Informant Ethel M. Gilling

(b) Address New Bloomfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/1947
(Month) (Day) (Year)

(c) Place: burial or cremation Middle River

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? _____

18. (a) Signature of funeral director Ray A. Holt

(b) Address New Bloomfield, Mo.

19. (a) May 18 - 47 (Date received local registrar)

(b) LeRoy Cleveland (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature E. Merle Rusk (M. D. or other) _____

Address New Bloomfield, Mo Date signed 5/16/47

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 5-28-47

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. 2605, working under my personal supervision.

Signed Ray A. Holt
Licensed Embalmer No. 2605
P. O. Address Ben D. Loomfield M

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.