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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 8 1948

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30759

Registration District No. 309 Primary Registration District No. 6050 Registrar's No.

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town West Alton
(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 .....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles 92

(c) City or town West Alton 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME John W. Nicholson

3. (b) If veteran, name war None

3. (c) Social Security No. 509-16-0197

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Flora Nicholson

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased November 12, 1888
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
59	10	9	..... hr. ..... min.

9. Birthplace West Alton (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER
12. Name Peter Nicholson
13. Birthplace ..... (City, town, or county) Scotland 4 (State or foreign country)

MOTHER
14. Maiden name Nancy Waldrip
15. Birthplace West Alton (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Mrs. Flora Nicholson
(b) Address West Alton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Hackmann-Baue, Inc
(b) Address 326 N. 6th. Str., St. Charles, Mo.

19. (a) 9-30-1948 (Date received local registrar) (b) [signature] (Registrar's signature) 21.6

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 21st
year 1948 hour 6 minute 50 A.M.

21. I hereby certify that I attended the deceased from July 30, 1947, to Sept. 17, 1948
that I last saw him alive on Sept 17, 1948;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary artery occlusion	1 hour
Due to coronary artery arteriosclerosis	5 yrs
Due to generalized arteriosclerosis	5 yrs
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

940

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 [signature] (M. D. or other) MD
Address St. Charles Mo. Date signed 9-22-48

(Licensed Embalmer's Statement on Reverse Side)

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 Frederick N. Bauer

Licensed Embalmer No. 4607

P. O. Address St. Charles, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.