

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

40491

State File No. _____

FILED DEC 27 1948
Registration District No. 487

Primary Registration District No. 3028

Registrar's No. 284

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

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution:
408 E. Third St.
(If not in hospital or institution, write street number or location)

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

In this community 5 1/2 years (years, months or days)

3: (a) PRINT FULL NAME COLUMBIA NICHOLS

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female / 5. Color or race white

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

6. (b) Name of husband or wife E. Townswend Nichols

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

7. Birth date of deceased April 9 1855
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>93</u>	<u>8</u>	<u>5</u>	hr. min.

9. Birthplace St. Mary's Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation retired housewife

11. Industry or business at home

MOTHER FATHER {

12. Name William Walden

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

14. Maiden name Katherine Paty

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

16. (a) Informant Mrs. Walter Martin

(b) Address Connor Hotel, Joplin, Mo.

17. (a) burial (b) Date thereof Dec 16, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Knell Mortuary

(b) Address Carthage, Missouri

19. (a) 12-16-1948 (b) G. B. Clenton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. 408 E. Third St.
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 14
year 1948 hour 6 minute 15 P.M.

21. I hereby certify that I attended the deceased from 12 Noon Dec 14, 1948, to 6:15 pm Dec 14, 1948
that I last saw her alive on Dec 14, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Senility with Senile dementia

Due to <u>none</u>	Duration <u>5 yrs</u>
Due to <u>none</u>	

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy none

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 _____

Signature George H. Wood (M. D. or other) _____
Address Carthage Mo Date signed 12/16/48

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 Robert H. Knell
Licensed Embalmer No. 4459
P. O. Address Carthage

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.