

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 40797

FILED JAN 14 1949

Registration District No. 5761Primary Registration District No. 5761Registrar's No. 54

## 1. PLACE OF DEATH:

(a) County Marion  
 (b) City or town Rural  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Marion County Infirmary  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 40 years  
 (Specify whether  
 In this community Lifetime  
 years, months or days)

3. (a) PRINT  
FULL NAMEDavid Nichols

## 3. (b) If veteran,

No

## 3. (c) Social Security No.

No.

4. Sex Male 5. Color or  
 race Negro

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

alive years7. Birth date of deceased JULY 17 1853  
 (Month) (Day) (Year)

## 8. AGE:

Years

Months

Days

If less than one day

8555hr. min.9. Birthplace Marion County, Missouri  
 (City, town, or county) (State or foreign country)10. Usual occupation Laborer

11. Industry or business

12. Name Peter Nichols13. Birthplace Missouri  
 (City, town, or county) (State or foreign country)14. Maiden name Julia Nichols15. Birthplace Missouri  
 (City, town, or county) (State or foreign country)16. (a) Informant Johnnie Nichols(b) Address Palmyra, Missouri17. (a) Burial (b) Date thereof 12/23/48  
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Palmyra Cemetery18. (a) Signature of funeral director Lewis Bond(b) Address Palmyra, Missouri19. (a) 12/27/48 (b) J. Viola Beer  
 (Date received local registrar) (Registrar's signature)

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Liberty Township  
 (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 22  
 year 1948 hour 5 minute 0 P. M.

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

## Immediate cause of death

Arterio Sclerosis

Due to

Due to

Other conditions  
 (Include pregnancy within 3 months of death)

## Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline  
 the cause of  
 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) Means of injury

23. Signature J. M. Scola (M. D. or other)Address Franklin, Mo. Date signed 12/28/48

MOTHER FATHER

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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..... *W. S. Lewis*

Licensed Embalmer No. *2582*

P. O. Address..... *Albany, Ill.*

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.

Registration District No. 209

Primary Registration District No. 5761

1. PLACE OF DEATH:

(a) County maison  
(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 \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME David Nichols

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ (if less than one day) \_\_\_\_\_ min.

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

10. Usual occupation General Laborer

11. Industry or business \_\_\_\_\_

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 \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

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

MOTHER FATHER

