

22532

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

No. 300

10.48

FILED JUL 30 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 187

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>217 Madison St.</u>                               |  | d. STREET ADDRESS (If rural, give location) <u>217 Madison St.</u>   |  |

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|---|--|---|---|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>MARTHA</u> b. (Middle) <u>NICHOLS</u> c. (Last) <u>NICHOLS</u> |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>July 22, 1949</u> |  |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>             |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>   |  |
| 8. DATE OF BIRTH <u>Sept. 25, 1852</u>  |  | 9. AGE (In years last birthday) <u>96</u> |   | IF UNDER 1 YEAR Months Days Hours Min.                                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>          |  | 10b. KIND OF BUSINESS OR INDUSTRY         |   | 11. BIRTHPLACE (State or foreign country) <u>Cooper County, Missouri</u> |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |  |   |   |  |  |

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|--|--|---|--|--|--|
| 13a. FATHER'S NAME <u>LaFayette Carlos</u>   |  | 13b. MOTHER'S MAIDEN NAME <u>(unknown) Carlos</u> |  | 14. NAME OF HUSBAND OR WIFE <u>Milton Nichols</u>                                    |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO. <u>None</u>               |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. W.T. Benedict, 217 Madison St.</u> |  |

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bright Disease</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Inflamed Kidney</u><br>DUE TO (c)<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><u>593X</u> |  |
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| 19a. DATE OF OPERATION                             |  | 19b. MAJOR FINDINGS OF OPERATION   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)           |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?                      |  |  |  |

22. I hereby certify that I attended the deceased from June 1, 1949, to July 22, 1949, that I last saw the deceased alive on July 21, 1949, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

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|--|--|---|--|---|--|
| 23a. SIGNATURE (Degree or title) <u>D. Boyd Simpson M.D.</u> |  | 23b. ADDRESS <u>646 Cherry St</u>   |  | 23c. DATE SIGNED <u>7-13-49</u>                                   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>      |  | 24b. DATE <u>July 24, 1949</u>  |  | 24c. NAME OF CEMETERY OR CREMATORY <u>New Providence Cemetery</u> |  |
|  |  | 24d. LOCATION (City, town, or county) (State) <u>Boone County, Missouri</u> |  |   |  |

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|--|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. <u>July 23 1949</u> |  | REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parker Funeral Service, Columbia, Mo.</u> |  |
|--|--|--|--|---|--|

(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED JUL 26 1949  
District Health Officer No. 9,  
District File Number

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4132

P. O. Address Columbia

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.