

FILED SEP 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29353

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>42</u>	PRIMARY REG. DIST. NO. <u>1000</u>	Registrar's No. <u>989</u>
1. PLACE OF DEATH a. COUNTY <u>BUCHANAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>BUCHANAN</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST-JOSEPH</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST-JOSEPH-</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>METHODIST-HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>2427-ST-JOSEPH-AVE. 0</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>DR. RAY-</u> b. (Middle) <u>K-</u> c. (Last) <u>NICHOLSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 9, 1949</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHT</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Nov. 22, 1885</u>	9. AGE (In years) (If under 1 year, last birthday) (If under 2 wks., Hours) (If under 2 mos., Days) (If under 2 yrs., Months) <u>63</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHIROPRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>LAMONI-IOWA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>D. F. Nicholson</u>		13b. MOTHER'S MAIDEN NAME <u>Minnie Blair</u>	14. NAME OF HUSBAND OR WIFE <u>Marie Nicholson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Marie Nicholson</u> ADDRESS <u>St. Joseph, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Cholelitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute Cholel cystitis, and Bronchial asthma.</u> DUE TO (c) <u>Acute Barbitol poisoning</u>		<u>1 week</u> <u>1 day.</u>
		11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>man apparently had taken salmol tablets to relieve his pain.</u>		
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) <u>585X</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		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 <u>viewed</u> the deceased from <u>on 9/9, 1949</u> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>1:00 p.m.</u> from the causes and on the date stated above.				
23a. SIGNATURE <u>H F Mundy</u> (Degree or title) <u>M.D. (Coroner)</u>		23b. ADDRESS <u>St Joseph Mo</u>		23c. DATE SIGNED <u>9/10/49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Sept. 12, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery, Lamoni,</u>	24d. LOCATION (City, town, or county) (State) <u>Iowa</u>
DATE REC'D BY LOCAL REG. <u>Sept. 14, 1949</u>		REGISTRAR'S SIGNATURE <u>G. B. Jenkins</u> 382	25. FUNERAL DIRECTOR'S SIGNATURE <u>Stoney Funeral Home</u> ADDRESS <u>St Joseph, Mo.</u>	

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

(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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Charles M. Harmon

Licensed Embalmer No. 4487

P. O. Address St Joseph

**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.