

FILED OCT 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29479

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 346

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Fulton</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Auxvasse</u>	
c. LENGTH OF STAY (In this place) <u>1 Week</u>		d. STREET ADDRESS (If rural, give location) <u>00</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Callaway Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>Bertram</u> c. (Last) <u>Nichols</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 3, 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	
8. DATE OF BIRTH <u>April 24, 1869</u>		9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR: Months <u>5</u> Days <u>9</u>	
IF UNDER 2 HRS: Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		

13a. FATHER'S NAME <u>James A. Nichols</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Michael</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
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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 ADDRESS <u>Dr. Frank J. Nichols, Marshall, Mo.</u>	
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia and myocardial infarction following severe trauma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Concussion chest wall + cerebral contusion lungs, severe multiple lacerations of face</u>			<u>1 week</u>	
	DUE TO (c) <u>neck, mouth, extremities, severe injuries, contusions incurred in accident on Fulton-Mokane highway 26 Sept. 49</u>			<u>26</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>County Road</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Fulton Callaway Mo.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Sept 26 1949 11A</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Head on collision on highway near Hans Marie, Mo (Callaway County, Mo.)</u>	

22. I hereby certify that I attended the deceased from 26 Sept 1949, to 3 Oct 1949, that I last saw the deceased alive on 3 Oct 1949, and that death occurred at 9 A. M., from the causes and on the date stated above.

23a. SIGNATURE <u>E. Rutledge York MD</u> (Degree or title)		23b. ADDRESS <u>Fulton, Mo</u>		23c. DATE SIGNED <u>3 Oct 49</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct 4, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mokane</u>		24d. LOCATION (City, town, or county) (State) <u>Mokane, Missouri</u>	
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DATE REC'D BY LOCAL REG. <u>Oct 4-1949</u>		REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u> 426		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Maugin Funeral Home, Fulton, Mo</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

14
12

District File Number _____
District Health Officer No. 9,
OCT 11 1949
RECEIVED

1949

OCT 18 1949

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 Walter J. Haines, Jr.
Licensed Embalmer No. 4557

P. O. Address Fulton, Mo.

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.