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FILED OCT 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34403
Registrar's No. 9

BIRTH NO. 124 REG. DIST. NO. 215 PRIMARY REG. DIST. NO. 5783

1. PLACE OF DEATH a. COUNTY Miller		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY MERI.	
b. CITY OR TOWN Rural Richwoods	c. LENGTH OF STAY (in this place) 5 days	c. CITY OR TOWN Rural-Richwoods	b. 06
d. FULL NAME OF HOSPITAL OR INSTITUTION Hancock Mo RFD 1		d. STREET ADDRESS (If rural, give location) Hancock Mo RFD 1	

3. NAME OF DECEASED (Type or Print) Mary E. Nichols			4. DATE OF DEATH (Month) (Day) (Year) Oct 1 1949		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH Oct. 23 1863	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months 11	IF UNDER 1 YEAR Days 8	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME Frank Lee		13b. MOTHER'S MAIDEN NAME Elizabeth Groves		14. NAME OF HUSBAND OR WIFE James Nichols	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS James Lee Hancock Mo RFD 1			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure				5 min
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cancer of right breast			yrs.
				1/200
				yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Oct 1 1949, to 10/1/49, that I last saw the deceased alive on 19, and that death occurred at 3:30 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Walter P. Nedges Coroner	23b. ADDRESS Iberia, Missouri	23c. DATE SIGNED 10/1/49
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24a. BURIAL, CREMATION REMOVAL (Specify) Burial	24b. DATE 10/2/49	24c. NAME OF CEMETERY OR CREMATORY Billings	24d. LOCATION (City, town, or county) (State) Iberia Mo.
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DATE REC'D BY LOCAL REG. Oct-3-49	REGISTRAR'S SIGNATURE Jessie Perkins	195	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Frank Adams Iberia, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Roran R. Adams

Licensed Embalmer No.

4207

P. O. Address

Iberville, La

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.