

FILED JAN 30 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43669

State File No. ....

BIRTH NO. <u>79953-49</u>		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>48</u>		
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>West Plains</u>		c. LENGTH OF STAY in this place <u>4 hrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>West Plains</u>		0465		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christa Hagan Hosp.</u>				d. STREET ADDRESS (If rural, give location)				
3. NAME OF DECEASED (First) <u>Bobby Leon</u> (Middle) <u>Nichols</u> (Last) <u>Nichols</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12-26-49</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Never</u>	8. DATE OF BIRTH <u>12-26-49</u>	9. AGE (In years last birthday)		OF UNDER 1 YEAR Months	OF UNDER 12 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Precept</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>West Plains, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>F. H. Nichols</u>			13b. MOTHER'S MAIDEN NAME <u>Ruby Fry</u>		14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>17-26-49</u>		17. INFORMANT'S SIGNATURE OR NAME <u>F. H. Nichols, Thomasville, MO</u> ADDRESS				
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>undetermined</u>				ANTECEDENT CAUSES				
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) <u>Baby delivered by section</u>				
DUE TO (c) <u>due to placenta praevia</u>								
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION <u>12/26/49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Placenta Praevia</u>				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 <u>12-26</u> , 19 <u>49</u> , to <u>12-26</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>12-26</u> , 19 <u>49</u> , and that death occurred at <u>1:00</u> p.m., from the causes and on the date stated above.								
23a. SIGNATURE <u>F. Callahan M.D.</u> (Degree or title)				23b. ADDRESS <u>West Plains, Mo</u>		23c. DATE SIGNED		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>12-28-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Callahan</u>		24d. LOCATION (City, town, or county) (State) <u>Howell, MO</u>		
DATE REC'D BY LOCAL REG. <u>1-18-50</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		FUNDING DIRECTOR'S SIGNATURE <u>Robertson</u> ADDRESS <u>West Plains, MO</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 1/23/50  
District Health Officer No. 5,  
District File Number 15064  
Date Filed 1/26/50

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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.....

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.