

FILED JAN 31 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1485  
State File No. ....

0480

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY OR TOWN Rural Prairie Twp		c. CITY OR TOWN Kansas City 3020	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jackson Co. Home		d. STREET ADDRESS 523 Grand Ave	
3. NAME OF DECEASED (Type or Print) a. (First) HOWARD b. (Middle) C. c. (Last) NICHOLSON		4. DATE OF DEATH (Month) (Day) (Year) 1-18-50	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH 6-22-1880
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Hanock, Maryland
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME unknown	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Jackson Co. Home - Rt. #4 - Indep. Mo.		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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		4201	
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 1-16, 1950, to 1-18, 1950, that I last saw the deceased alive on 1-18, 1950, and that death occurred at 5:10 a.m., from the causes and on the date stated above.			
23. SIGNATURE J.W. Greene, M.D.		23b. ADDRESS Independence Mo 418/50	
23c. DATE SIGNED 1/18/50		24. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 1-18-50		24c. NAME OF CEMETERY OR CREMATORY Heis Summit	
24d. LOCATION (City, town, or county) Heis Summit Mo		(State)	
DATE REC'D BY LOCAL REG. Jan 18, 1950		REGISTRAR'S SIGNATURE Howard C. Samson 378	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS 2708 Camp St Heis Summit	

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

JAN 26 RECD

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.....

working under my personal supervision.

*Not Embalmed*

Student Embalmer No. ....

Signed *E. B. Longford* .....

Signed.....  
Student Embalmer

Licensed Embalmer No. *3833* .....

P. O. Address *Leis Summit* .....

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.