S. No. 300
V. 10.48

FILED JUN 16 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19663

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 204

0143
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
a. COUNTY: Calloway
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fulton
c. LENGTH OF STAY (in this place): 2 Months 11
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospt No 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Audrain
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Martinsburg 0040 1
d. STREET ADDRESS (If rural, give location): —

3. NAME OF DECEASED (Type or Print)
a. (First): MANUEL
b. (Middle):
c. (Last): NICKENS

4. DATE OF DEATH (Month) June (Day) 8 (Year) 1952

5. SEX: M 2
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 1
8. DATE OF BIRTH: Nov 18 1860
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months 7 Days 20 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: DK
11. BIRTHPLACE (State or foreign country): Mo
12. CITIZEN OF WHAT COUNTRY?: America

13a. FATHER'S NAME: Thomas Nickens
13b. MOTHER'S MAIDEN NAME: Susan Dillon
14. NAME OF HUSBAND OR WIFE: Sallie Nickens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): DK
16. SOCIAL SECURITY NO.: DK
17. INFORMANT'S SIGNATURE OR NAME: Records State Hospt 1 — ADDRESS: Fulton

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic Myocarditis

ANTECEDENT CAUSES
Morbid 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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 4222
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 8, 1952, *to* June 8, 1952, *that I last saw the deceased alive on* Jan 8, 1952 *and that death occurred at* 8:40 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE: R. G. Price (Degree or title): MDO
23b. ADDRESS: Fulton Mo
23c. DATE SIGNED: 6/8/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: June-10-52
24c. NAME OF CEMETERY OR CREMATORY: Martinsburg Mo
24d. LOCATION (City, town, or county) (State): Martinsburg Mo

DATE REC'D BY LOCAL REG.: June 9-1952
REGISTRAR'S SIGNATURE: Maretta Lawrence 4260
25. FUNERAL DIRECTOR'S SIGNATURE: K B Wells — **ADDRESS**: Wellsville Mo

(Licensed Embalmer's Statement on Reverse Side)

JUL 29 1955

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 K B Wells

Licensed Embalmer No. 1588

P. O. Address Wellsville 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.