

FILED NOV 1 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35775**  
**9665**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Louis</b>	c. LENGTH OF STAY (in this place) <b>3 Weeks</b>	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>		STREET ADDRESS (If rural, give location) <b>12 5077 Washington 212 70</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Lester</b> b. (Middle) <b>Gilbert</b> c. (Last) <b>Nichols</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 24, 1954</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>April 27, 1903</b>	9. AGE (In years last birthday) <b>51</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Paris Tennessee</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			

13a. FATHER'S NAME <b>Robert Lawson Nichols</b>	13b. MOTHER'S MAIDEN NAME <b>Emma May Pierce</b>	14. NAME OF HUSBAND OR WIFE <b>Divorced</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>488 05 6183</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Albert Nichols</b>	ADDRESS <b>3408 Coles Ave.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bacterial Endocarditis,</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Pneumonitis,</b>		<b>1 week</b>
	DUE TO (c) <b>Viruses infection,</b>		<b>2 weeks</b>
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 <b>492x</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>...</b>
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22. I hereby certify that I attended the deceased from **Oct. 4, 1954** to **Oct. 24, 1954**, that I last saw the deceased alive on **Oct. 23, 1954**, and that death occurred at **12:00 PM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Joseph H. Davis M.D.</b>	23b. ADDRESS <b>906 Olive St.</b>	23c. DATE SIGNED <b>Oct. 25, 1954</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Oct 27 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mount Lebanon Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>
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DATE RECD BY LOCAL REG. <b>Oct 25 1954</b>	REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Collier Mortuary</b>	ADDRESS <b>10123 St. Chas. Rd.</b>
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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.....  
Signature of Student Embalmer

Signed..... *Sheldon Collins*

Licensed Embalmer No. *338*

P. O. Address *10123 St. 1*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.