

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40821
STATE FILE NUMBER
5354

FILED DEC 2 - 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5354

V. S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <i>518 S. Colorado</i>		Length of stay in lb <i>47 yrs.</i>	d. STREET ADDRESS <i>518 S. Colorado</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>GEORGE</i> Middle <i>Phillip</i> Last <i>NICOLAI</i>			4. DATE OF DEATH Month <i>11</i> Day <i>13</i> Year <i>1957</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Aug-26-1866</i>	9. AGE (In years birthday) <i>91</i>	IF UNDER 1 YEAR Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>
10a. USUAL OCCUPATION (Give kind of work done in the most working life, if retired) <i>Sheet Metal</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Billsbury Mills</i>	11. BIRTHPLACE (City and state or country) <i>Rosday, Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13a. FATHER'S NAME <i>Unknown</i>		13b. MOTHER'S MAIDEN NAME <i>Unknown</i>		14. NAME OF HUSBAND OR WIFE <i>Lydia</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>500-14-8559</i>	17. INFORMANT <i>Alta Nicolai</i>		Address <i>518 S. Colorado I.C. Mo.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic myocarditis</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Coronary Arteriosclerosis</i> <i>15 years</i>					
DUE TO (c) <i>slight Arteriosclerosis</i> <i>15 years</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4201</i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour <i>-</i> Month, Day, Year <i>-</i> a.m. <i>-</i> p.m. <i>-</i>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>1953</i> to <i>11-12-1957</i> and last saw him ^{live} alive on <i>11-12-57</i> Death occurred at <i>1:15</i> P. M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>H.G. Jamison</i> (Degree or title) <i>D.O.</i>			22b. ADDRESS <i>5400 Indep. Ave.</i>		22c. DATE SIGNED <i>11-13-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11-16-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Mourah Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>I.C. Missouri</i>
24. FUNERAL DIRECTOR <i>C.H. Blackman & Son Inc.</i> ADDRESS <i>I.C. Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>11-13-57</i>		26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. H.G. Jamison
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 securing the medical certification in the specific manner required by 193.140 MoRS 1949.

(Licensed Embalmer's Statement on Reverse Side)



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 *W. C. Quinn*

Licensed Embalmer No. *4879*

P. O. Address *W. C. Quinn*

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.