Health, & Welfare Public Service

S. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED APR 15 1958

58-010872
STATE FILE NUMBER

Registration District No. 254 Primary Registration District No. 5867 Registrar's No. 22

1. PLACE OF DEATH
a. COUNTY: Oregon
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Thayer Township — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): — Length of stay in lb: 23 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Oregon 6750
c. CITY OR TOWN: Thayer Township — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Mary Middle: Lou Last: Nickels

4. DATE OF DEATH: Month: March Day: 23 Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH: Dec. 2, 1882
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months 3, Days 21 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (City and state or country): Camp, Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: James L. Cherry
13b. MOTHER'S MAIDEN NAME: Easter Todd
14. NAME OF HUSBAND OR WIFE: James L. Nickels

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lottie Tharp, Address: Wilson, Arkansas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 5 mos
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): Tumor of Left Lung — 6 year
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 163X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 0
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Oct 1951, to March 23 1958 and last saw her/him alive on March 23 1958
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): O. W. Cooper MPO
22b. ADDRESS: Thayer M
22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3-26-1958
23c. NAME OF CEMETERY OR CREMATORY: Saddle Cemetery
23d. LOCATION (City, town, or county) (State): Fulton County, Arkansas

24. FUNERAL DIRECTOR — ADDRESS: Hand Carter Thayer M
25. DATE RECD. BY LOCAL REG.: 3-29-58
26. REGISTRAR'S SIGNATURE: Arthur Wolff

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 .....

Licensed Embalmer No. 4516

P. O. Address .....

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.