

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032114  
STATE FILE NUMBER

FILED OCT 15 1958 Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 116

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Shoal Twp.</b>		c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3mi. S. Cameron, Mo.</b>		d. STREET ADDRESS (If outside, give location) <b>3006 Tracy</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>ARTIE ANNABELLE NICKELL</b>			4. DATE OF DEATH Month Day Year <b>Oct. 5, 1958</b>		
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 - 17 - 1931</b>	9. AGE (In years last birthday) <b>27</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	11. BIRTHPLACE (City and state or country) <b>Tina Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Harry McCracken</b>	13b. MOTHER'S MAIDEN NAME <b>Cora McCracken Deo</b>	14. NAME OF HUSBAND OR WIFE <b>Eldon G. Nickell</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>488-32-7956</b>	17. INFORMANT Address <b>Eldon Nickell 3006 Tracy K.C. Mo</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing Injury to Head</b>		INTERVAL BETWEEN ONSET AND DEATH <b>intermediate</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>automobile accident</b>
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20c. TIME OF INJURY Hour Month, Day, Year <b>6 a.m. 10-5-58</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>highway 69</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Clinton, Mo.</b>
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>6:00 a</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>Shed Warren, D.O., Coroner</b>	22b. ADDRESS <b>Lathrop, Mo.</b>	22c. DATE SIGNED <b>10-5-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Oct. 5 58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Lound Cemetary</b>	23d. LOCATION (City, town, or county) (State) <b>Dawn Mo. Miss Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Poland Funeral Home Cameron Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Oct 6 - 58</b>	26. REGISTRAR'S SIGNATURE <b>Frances D Crawford</b>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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APR 6 1959

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 *Robert F. Poland* .....

Licensed Embalmer No. *4777*  
*222* .....

P. O. Address ..... *Cambridge* .....

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.