

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000048

FILED VS FEB 2 1960 **4**

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **134** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY ATCHISON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HOLT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FAIRFAX		Length of stay in 1b 3 DAYS	c. CITY OR TOWN MOUND CITY Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION COMMUNITY HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HUGH Middle _____ Last NICHOLS			4. DATE OF DEATH Month JAN. Day 27 Year 1960		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/4/1888	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months _____ Days _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY COMMON LABOR	11. BIRTHPLACE (City and state or country) SALEM, IND.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME WILLARD A. NICHOLS	13b. MOTHER'S MAIDEN NAME LAURA E. BOLING	14. NAME OF HUSBAND OR WIFE EDITH NICHOLS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 500-07-8939	17. INFORMANT MRS. EDITH NICHOLS - MOUND CITY, MO.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA		INTERVAL BETWEEN ONSET AND DEATH 1 Hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CONGESTIVE HEART FAILURE		3 days.
DUE TO (c) DISSECTING AORTIC ANEURYSM		3 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 **1st week Jan. 1960** to **Jan. 27, 1960** and last saw him alive on **Jan. 27, 1960**
Death occurred at **Fairfax Hospital** **11 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James Humphreys M.D.	22b. ADDRESS MOUND CITY, MO.	22c. DATE SIGNED Jan. 29, 1960
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1/29/1960	23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cem.	23d. LOCATION (City, town, or county) (State) GRAHAM, MISSOURI
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24. FUNERAL DIRECTOR James H. Crawford, Mound City, Mo.	25. DATE RECD. BY LOCAL REG. Jan 31, 1960	26. REGISTRAR'S SIGNATURE Adrian J. Schuler
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James H. Crawford

Licensed Embalmer No. 4796

P. O. Address Mound City

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.