

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

80-034157

SEP 19 1960

INDEXED

Registration District No. 70 Primary Registration District No. _____ Registrar's No. 39

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Clark</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Clark</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Des. Moines Township</u>		Length of stay in 1b <u>76 yrs.</u>		c. CITY OR TOWN <u>Alexandria</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rural</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Elwell Nichols</u>				4. DATE OF DEATH Month Day Year <u>Sept. 11-1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7/8/1873</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>New Jersey</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S. A.</u>	
13a. FATHER'S NAME <u>David Nichols</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Zane</u>		14. NAME OF HUSBAND OR WIFE <u>Hessie Nichols</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Laverne Nichols, Alexandria Mo.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>arteriosclerotic Heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>30 da.</u>	
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 <u>Sept 10, 1960</u> to <u>Sept 11, 1960</u> and last saw <u>her</u> alive on <u>Sept 10, 1960</u> Death occurred at <u>5:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Regree or title) <u>Cecil L. Watson, M.D.</u>				22b. ADDRESS <u>Kahoka, Mo.</u>		22c. DATE SIGNED <u>9-14-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 13-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sand Cemetery</u>		23d. LOCATION (City, town, or county) <u>Clark</u>		STATE <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Chas. C. Tutting - Kahoka Mo.</u>			ADDRESS	DATE RECD. BY LOCAL REG. <u>9/14-60</u>	26. REGISTRAR'S SIGNATURE <u>J. H. Braggins</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Chas. L. Luttinger

Licensed Embalmer No. 2465
P. O. Address Illinois

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.