

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-039308**

FILED VS NOV 15 1960 *280*

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. *77*

NDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Platte</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Weston</b>		a. STATE <b>mo.</b>		b. COUNTY <b>Platte</b>	
Length of stay in 1b <b>38 yrs.</b>		c. CITY OR TOWN <b>Weston</b>		d. STREET ADDRESS (If outside, give location) <b>RFD Weston</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>Home</b>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>BERNICE</b>		Middle <b>NICHOLS</b>		Month <b>11-</b>		Day Year <b>1- 1960</b>	
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>2/18/1905</b>	9. AGE (last birthday) <b>55</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Little Rock, Ky.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Wallace Terrell</b>			13b. MOTHER'S MAIDEN NAME <b>Maggie May Crouch</b>		14. NAME OF HUSBAND OR WIFE <b>Wilbur Nichols</b>		
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>none</b>		17. INFORMANT Address <b>Mr. Wilbur Nichols</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
IMMEDIATE CAUSE (a) <b>Adenocarcinoma of stomach with metastasis</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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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. _____							
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.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE		
21. I attended the deceased from <b>Aug. 1, 60</b> to <b>Nov. 1, 60</b> and last saw her <sup>her</sup> alive on <b>Nov. 1, 1960</b> Death occurred at <b>8 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>B. Rollins</i> (Degree or title)				22b. ADDRESS <b>Weston, Missouri</b>		22c. DATE SIGNED <b>11/2/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/3/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Ridge Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Platte County, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Vaughn Funeral Home Weston, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>Nov-3-1960</b>		26. REGISTRAR'S SIGNATURE <i>B. Rollins</i>			

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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Dale L. Maud

Licensed Embalmer No. 5106

P. O. Address Weston, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.