OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

ENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 359 STATE FILE NUMBER 61-013403

FILED APR 17 1961

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital
Inside Limits Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Texas b. COUNTY Grayson
c. CITY OR TOWN Tioga, Texas
Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) Tioga, Texas
Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First ROBERT Middle LeROY Last NICHOLSON
4. DATE OF DEATH Month April Day 10 Year 1961
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married X Widowed ☐ Divorced ☐
8. DATE OF BIRTH 7/19/1904
9. AGE (last birthday) 56
IF UNDER 1 YEAR Months 6 Days 21
IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (City and state or country) Tioga, Texas
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Charles Nicholson
13b. MOTHER'S MAIDEN NAME Effie Willett
14. NAME OF HUSBAND OR WIFE Never married
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Raymond Chapman, Address 2506 Cedarbrooke, Springfield, Missouri

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) Perinephric Abscess – left — INTERVAL BETWEEN ONSET AND DEATH 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Chronic pyelonephritis — 10 years
DUE TO (c) Neurogenic Bladder — 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Residual deformity – poliomyelitis.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES X NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ 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 4-8-61, to 4-10 and last saw (her/him) alive on 4-9-61
Death occurred at 6:35 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Neil R. Auner (Degree or title) MD
22b. ADDRESS 608 S. Glenstone Springfield, Mo
22c. DATE SIGNED 4-11-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 4/10/1961
23c. NAME OF CEMETERY OR CREMATORY Tioga Cemetery
23d. LOCATION (City, town, or county) Tioga (State) Texas

24. FUNERAL DIRECTOR Ralph Thieme, Springfield, Mo. ADDRESS 1200 Boonville
25. DATE RECD. BY LOCAL REG. 4-14-61
26. REGISTRAR'S SIGNATURE Effie S. Mellen

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

DEC 27 1961

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 36.32

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.