

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-020986**

STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 615B

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Greene</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Length of stay in lb <u>2 Days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Springfield Baptist Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u> c. CITY OR TOWN <u>Ash Grove</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>RFD 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ada</u> Middle <u>Florence</u> Last <u>Nicholson</u>			<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>25</u> Year <u>1961</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12-11-1876</u>	<b>9. AGE</b> (last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housekeeping</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Greene Co. Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>George Squibb</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Amanda Breeden</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>K.A. Nicholson</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Lyman Nicholson</u> Address <u>Ash Grove R2</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral artery hemorrhage 2 days</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
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"/> N- <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>24 June 1961</u> to <u>25 June 1961</u> and last saw <u>her</u> alive on <u>25 June 1961</u> Death occurred at <u>6:00</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Francis M. Maple MD</u>			<b>22b. ADDRESS</b> <u>Springfield, MO</u>		<b>22c. DATE SIGNED</b> <u>29 June 1961</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>June 27 1961</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Johns Chapel</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Greene Co. Mo.</u>		
<b>24. FUNERAL DIRECTOR</b> <u>J.W. Duch</u>		ADDRESS <u>Ash Grove Mo</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-3-61</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Effie S. Melton</u>		

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 Richard E. Watts

Licensed Embalmer No. 4652

P. O. Address Ash Grove,

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.