APR 30 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

8523

1. PLACE OF DEATH

County Howell — Registration District No. 384 — File No. 27

Township ~~Howell~~ — Primary Registration District No. 4777 — Registered No.

City West Plains (No. ..... St. ..... Ward)

2. FULL NAME Johnny Adam Nichols

(a) Residence. No. ..... St., ... Ward. Dillaware Mo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1920

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
[illegible]				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mo
(STATE OR COUNTRY) Alley Mo

PARENTS

10. NAME OF FATHER John Nichols

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Alley
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown

14. INFORMANT Child - Deceased
(Address) Alley Mo

15. FILED 3-14-1930 O. A. Heinrich REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 14 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-14-, 1930, to 3-14-, 1930 that I last saw him alive on 3-14-, 1930, and that death occurred, on the date stated above, at 2:15 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Empyema Left
110A
107A
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Left Pneumonia
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Alley Mo

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 3-13-30

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Operation

(Signed) R. E. Hoyman, M. D.

3-14-, 1930 (Address) West Plains Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Dillaware Mo.	3-15 1930
20. UNDERTAKER	**ADDRESS**
Hal Flemburgh	West Plains Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH.
County: Dowell — Registration District No.: 384 — File No.: 9
Township: — Primary Registration District No.: 4227 — Registered No.: 27
City: West Plains — St. — Ward)

2. FULL NAME: Johnny Adam Nichols

(a) Residence. No. — St., — Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U.S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S.

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dont know 1920

7. AGE: Years: 9 — Months: Dont know — Days: — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 3-14, 19 30 O O A Heinrich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mar 14 1930

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Emphysema Left
Bronchopneumonia
A. Left (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Left Pneumonia
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed), M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

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