

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

Do not use this space.

1239

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Rau Primary Registration District No. _____
City Kansas City (No. General Hospital)

File No. _____
Registered No. 70
St. _____ Ward _____

2. FULL NAME

John Nichols
(a) Residence, No. 4038 Summit St., _____ Ward. _____
(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 <u>M</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>12-26-30</u>		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Child</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <u>Kansas City</u> (STATE OR COUNTRY) <u>Missouri</u>		
PARENTS	10. NAME OF FATHER <u>Frank Nichols</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Green</u> (STATE OR COUNTRY) <u>Mo</u>	
	12. MAIDEN NAME OF MOTHER <u>Bessie Harris</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Kansas City</u> (STATE OR COUNTRY) <u>Missouri</u>	
14. INFORMANT <u>Records Clerk</u> (Address) <u>K.C. Genl Hosp.</u>		
15. FILED <u>Jan 6 1931</u> M. M. <u>Olson</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-6 1931

17. I HEREBY CERTIFY, That I attended deceased from 12-26, 1930, to 1-6, 1931 that I last saw L. M. alive on 1-6, 1931, and that death occurred, on the date stated above, at 4:50 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Prematurity

CONTRIBUTORY (SECONDARY) 159 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
8 IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS?
1/6 (Signed) W. G. Williams M. D.
1/6 1931 (Address) K.C. General Hosp.

*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 <u>St Marys Cemetery</u>	DATE OF BURIAL <u>1-6-31</u>
20. UNDERTAKER <u>John J. O'Keefe</u>	ADDRESS <u>1-6-1931</u>

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

