

REC'D MAR 9 1939

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

5859

Do not use this space.

1. PLACE OF DEATH *Boone* ² Registration District No. *73*
 (a) County *Boone* ¹ Primary Registration District No. *3006*
 (b) Township *Columbia* Registered No. *19*
 (c) City *Columbia* (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *James M Nichols*
 (a) Residence, No. *603 Elm St* St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Bachelor*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Bachelor*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 24 1854*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85 *x* *7*
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Retired*
 9. Industry or business in which work was done, as saw mill, bank, etc. *Farmer*
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Boone Co Mo*

FATHER 13. NAME *Wm Nichols*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*

MOTHER 15. MAIDEN NAME *Eliza Ann Forbis*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*

17. INFORMANT (ADDRESS) *Wm Ira Nichols*
603 Elm St

18. BURIAL, CREMATION, OR REMOVAL PLACE *New Liberty* DATE *Feb 2 1939*

19. FUNERAL DIRECTOR (ADDRESS) *R. Powell*

20. FILED *2/2/1939* *Allie Selby* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 1st 1939*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 4th 1939* to *Feb 1st 1939*
 I last saw him alive on *Feb 5th 1939* Death is said to have occurred on the date stated above, at *12:20 P.M.*
 The principal cause of death and related causes of importance were as follows:
Paralysis

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify *S. A. Priddy*, M. D.
 (Signed) *S. A. Priddy*
 (Address) *Columbio Mo.*

1798

STATEMENT BY LICENSED EMBALMER

Lyman H. Sprinkle, Licensed Embalmer No. *4013*
hereby certify that the body recorded on the reverse side of this certificate was embalmed by *Artemus & Cairns*

..... L. E.
No. or by Registered Apprentice No.
working under my personal supervision.

Signed *Lyman H. Sprinkle*
Licensed Embalmer No. *4013*

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.)

... Direct ...

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

5839
Do not use this space.

1. PLACE OF DEATH

(a) County Boone Registration District No. 73
(b) Township Columbia Primary Registration District No. 3006 Registered No. 19
(c) City Columbia (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

James M. Nichols
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-1, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from Feb 4/1939 to Feb 6/1939
I last saw him alive on Feb 3, 1939. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS 85 MONTHS _____ DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.

Paralysis
Date of onset _____

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

87 1/2
Contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 1939

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____, 1939 Local Registrar.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 1939
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) G. A. Bradford, M. D.
(Address) Columbia

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
H. C. STEWARTS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
COLUMBIA, MISSOURI

