

REC'D MAY 10 1939

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

13808  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 395  
(b) Township Kaw Primary Registration District No. 2007 Registered No. 1562  
(c) City Kansas City (d) Street No. Trinity Lutheran Hospital 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

(a) Residence, No. 242 Rezin O. Nicholson St.  Paola, Kansas  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Maude</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 19, 1889</u>		
7. AGE YEARS <u>49</u>	MONTHS <u>10</u>	DAYS <u>23</u>
If LESS than 1 day, ..... hrs. or ..... min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Druggist</u>	
	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
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Miami Co. Kansas</u>		
FATHER	13. NAME <u>Rezin O. Nicholson</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>	
MOTHER	15. MAIDEN NAME <u>Kate Cyster</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Wash. D.C.</u>	
17. INFORMANT (ADDRESS) <u>Maude Nicholson Paola, Kansas</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Paola, Kansas</u> DATE <u>4-14-39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Ray Wilson Paola, Kans.</u>		
20. FILED <u>Apr 13, 1939</u> M. M. Brown Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 12, 1939

22. I HEREBY CERTIFY, that I attended deceased from Mar. 26, 1939, to April 12, 1939.  
I last saw him live on April 13, 1939. Death is said to have occurred on the date stated above, at 3:25 p.m.  
The principal cause of death and related causes of importance were as follows:  
Chronic recurrent appendicitis  
Pelvic Peritonitis  
Date of onset

Other contributory causes of importance: 121

Name of operation Appendectomy Date of 4-10-39  
What test confirmed diagnosis? ..... Was there an autopsy? Yes

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? no  
If so, specify .....  
(Signed) Robert M. Myers, M. D.  
(Address) 1025 Duilio Bldg

WRITE PLAINLY, WITH UNWRITING 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.

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**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.**