REC'D AUG 7 1939

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

24756
Do not use this space.

**1. PLACE OF DEATH**

(a) County Jackson — Registration District No. 399

(b) Township Kan — Primary Registration District No. 1002 — Registered No. 2969

(c) City Kansas City — (d) Street No. 3843 Summitt 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** Clyde W. Nichols

(a) Residence, No. 3843 Summit St. (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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mrs Lucile Nichols

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Mar 31 - 1896

7. AGE: 43 YEARS — MONTHS: 4 — DAYS: 21 — If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: unemployed
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): Paris Ark 1

FATHER
13. NAME: Dave Nichols 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): unknown 9

MOTHER
15. MAIDEN NAME: unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): unknown

17. INFORMANT (ADDRESS): Mrs Lucile Nichols 3843 Summitt

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Ozark Ark DATE: 7-23, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): C. R. Theisen Funeral Home

20. FILED: 7-23, 1939 Mo M. Crowe
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 7-20-39, 19

22. I HEREBY CERTIFY, That I attended deceased from Deputy Coro, 19 to , 19
I last saw ... alive on ..., 19 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:

Bullet Wound of Head — Date of onset
167

Other contributory causes of importance:

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

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Suicide Date of injury 7-20-39, 19
Where did injury occur? Home (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury: Bullet wound of Head
Nature of injury: Fract Skull Fac Bone

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Russell W. Jones, M. D.
(Address) Kan

(Licensed Embalmer's Statement on Reverse Side)

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.

## 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.**