

No. 2
13-40
17-39
X23159

State File No. _____

Registration District No. _____

Primary Registration District No. 3008

Registrar's No. 312

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days
(Specify whether)

In this community 3
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway

(c) City or town Cedar City Missouri
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULLNAME CLYDE E Nichols

3. (b) If veteran, name war _____

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 25
year 1940 hour 7 minute 15 P M.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from 11-27, 1940 to 11-25, 1940
that I last saw him alive on 11-25, 1940
and that death occurred on the date and hour stated above.

7. Birth date of deceased NOVEMBER 22 1866
(Month) (Day) (Year)

Immediate cause of death Arteriosclerosis

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>0</u>	<u>3</u>	hr. _____ min.

Due to _____

Due to _____

9. Birthplace SEDALIA, MISSOURI
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation CARPENTER

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name MARCELLUS Nichols

13. Birthplace DUMFRIES
(City, town, or county) (State or foreign country)

14. Maiden name SARAH E. TRUING

15. Birthplace Callaway Co Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address _____

22. If death was due to external causes, fill in the following: 70

(a) Accident, suicide, or homicide (specify) _____

17. (a) Removal (b) Date thereof Nov. 25 '40
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(c) Place: burial or cremation Jefferson City MO

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 1st

18. (a) Signature of (funeral director) Walter Gordon

(b) Address Jefferson City MO

While at work? _____ (Specify type of place)

(e) Means of injury _____

19. (a) Nov. 25, 1940 (b) D. N. Crews
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) [Signature]

Address State Hospital Jefferson City Date signed 11/25/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Ferd P Dulle*

Licensed Embalmer No. *3890*

P. O. Address *Jefferson City, Mo*

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, fact should be so stated above.