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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED JAN 20 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42087

State File No. _____

Registration District No. 400

Primary Registration District No. 5558B

Registrar's No. 196

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Lees Summit
(c) Name of hospital or institution: 1 mi North - RR # 31
(d) Length of stay: In hospital or institution 1 year
In this community 1 year

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Lees Summit
(d) Street No. 1 mi North - RR # 31
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME

Mildred Mae Nichols

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex F 1 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Walter Nichols 6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased Oct - 15 - 1899

8. AGE: Years 42 Months 2 Days 16

9. Birthplace Ellston Iowa

10. Usual occupation Housewife

11. Industry or business own home

12. Name Roy H. Christy

13. Birthplace Ringold Co Iowa

14. Maiden name Bessie Hallingworth

15. Birthplace Ringold Co Iowa

16. (a) Informant Walter Nichols

(b) Address Lees Summit Mo

17. (a) Burial (b) Date thereof 1-4-42

(c) Place: burial or cremation Lees Summit Mo

18. (a) Signature of funeral director N. B. Langford

(b) Address Lees Summit Mo

19. (a) (b) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 31 year 1941 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from 3-17 1941 to 12-31 1941 that I last saw her alive on 12-30 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Led transverse colon with extension into stomach
Due to stomach

Other conditions: H62
(include pregnancy within 3 months of death)

Major findings: Inoperable carcinoma of transverse colon with extension into stomach & mesentery

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature [Signature] (M. D. or other) [Signature]
Address Lees Summit Mo Date signed 1/14/42

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

18
8
0

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 *W. B. Longford*

Licensed Embalmer No. *3833*

P. O. Address *Los Summit*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42087

Registration District No. 400

Primary Registration District No. 5553B

Registrar's No.

1. PLACE OF DEATH: Jackson Rural

(a) County.....
 (b) City or town.....
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:.....
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
 (c) City or town.....
 (If outside city or town limits, write "RURAL")
 (d) Street No.....
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Mildred M. Nichols

3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1941 hour..... minute..... M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased Oct 15 1891
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.
 Immediate cause of death.....

8. AGE: Years 42 Months 2 Days 19 If less than one day..... min.

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

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

10. Usual occupation.....
 11. Industry of business.....

MOTHER FATHER

12. Name.....
 13. Birthplace..... (City, town, or county) (State or foreign country)
 14. Maiden name.....
 15. Birthplace..... (City, town, or county) (State or foreign country)

Major findings:
 Of operations.....
 Of autopsy.....

16. (a) Informant.....
 (b) Address.....

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify).....
 (b) Date of occurrence.....

17. (a)..... (b) Date thereof.....
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation.....

(c) Where did injury occur?..... (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?.....
 While at work?..... (Specify type of place) (e) Means of injury.....

18. (a) Signature of funeral director.....
 (b) Address.....

23. Signature..... (M. D. or other).....
 Address..... Date signed.....

19. (a) 1-4-42 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

