

FILED NOV 24 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38342**
Registrar's No. **4675**

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **JACKSON**
(b) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **GENERAL HOSPITAL NO. 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **31 DAYS**
(Specify whether
In this community **17 YRS.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON 48**
(c) City or town **KANSAS CITY 3**
(If outside city or town limits, write "RURAL")
(d) Street No. **2817 TERRACE 8**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **NA**

3. (a) PRINT FULL NAME **OWEN NICHOLS**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **MALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **WIDOWED**
(b) Name of husband or wife **Carol Nichols** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **MARCH 1, 1867**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 8 2
hr. min.

9. Birthplace **BATON ROUGE LOUISIANA**
(City, town, or county) (State or foreign country)

10. Usual occupation **LABORER**

11. Industry or business

MOTHER FATHER { 12. Name **UNKNOWN** 9
13. Birthplace **UNKNOWN** 9
(City, town, or county) (State or foreign country)
14. Maiden name **UNKNOWN**
15. Birthplace **UNKNOWN** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **ZENOBIA BROWN (DAUGHTER)**
(b) Address **1808 E. 17th St.**
17. (a) **BURIAL** (b) Date thereof **11/18/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Lincoln**
18. (a) Signature of funeral director **W. J. K. R. M.**
(b) Address **1212 West St. K. R. M.**
19. (a) **11-8-47** (b) **Sheldine Holden**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOVEMBER**, day **3**,
year **1947** hour **7:** minute **00 P.M.**

21. I hereby certify that I attended the deceased from **OCTOBER 3, 1947** to **NOVEMBER 3, 1947**;
that I last saw him alive on **NOVEMBER 3, 1947**;
and that death occurred on the date and hour stated above.
Immediate cause of death **CEREBRAL VASCULAR ACCIDENT**

Due to **HYPERTENSIVE TYPE OF HEART DISEASE**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **930**

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____ (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 **0**

23. Signature **Sheldine Holden** (M. D. or other) **M.D.**
Address **GENERAL HOSPITAL NO. 2** Date signed **11/4/47**

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 *E. Sterling Bells*

Licensed Embalmer No. *3178*

P. O. Address. *1212 Vine K.C.*

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.