S. No. 2
—1/47
17:39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 23 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35176
Registrar's No. 2300

Registration District No. 377
Primary Registration District No. 6076

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 Days (Specify whether
In this community 28 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Saint Clair 999
(c) City or town Lovejoy 11
(If outside city or town limits, write "RURAL")
(d) Street No. 206 Washington Street 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME NICHOLSON, Harvey Lynn
3. (b) If veteran, name war WW-2
3. (c) Social Security No. Unknown
4. Sex Male 2
5. Color or race Colored
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Cora Belle Nicholson
6. (c) Age of husband or wife if alive 29 years
7. Birth date of deceased March (Month) 27 (Day) 1911 (Year)

8. AGE: Years 37 Months 6 Days 5 If less than one day hr. min.

9. Birthplace Carlyle, Arkansas (City, town, or county) (State or foreign country)
10. Usual occupation Chauffeur
11. Industry or business W.S. Engineers Depot
FATHER
12. Name Albert Nicholson
13. Birthplace Hazon (City, town, or county) Arkansas (State or foreign country)
MOTHER
14. Maiden name Maggie Trice
15. Birthplace Little Rock (City, town, or county) Arkansas (State or foreign country)
16. (a) Informant Registrar, VA Hospital
(b) Address Jefferson Barracks, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9-48 (Month) (Day) (Year)
(c) Place: burial or cremation Nat'l.Cem.Jeff.Bks.Mo.
18. (a) Signature of funeral director Marshall Fu.Home
(b) Address 2205 Missouri Ave. E.St.Louis,Ill.
19. (a) 10-6-48 (Date received local registrar) (b) Cecil A. Z. Sharp, M.D. B.M. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 2
year 1948 hour 11:45 minute P. M.

21. I hereby certify that I attended the deceased from September 20, 1948, to October 2, 1948; that I last saw him alive on October 2, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death MALIGNANT TUMOR OF BRAIN	Unk.
Due to - 54b	
Due to -	
Other conditions - (Include pregnancy within 3 months of death)	

Major findings: Of operations Craniotomy (date Unk.)
Of autopsy Autopsy performed (See cause of death)

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) None
(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? (Specify type of place)
While at work? L.E. Stilwell (Specify injury) 0

23. Signature L.E.Stilwell, Chief, Professional Services M.D.
Address VA Hosp. Jeff.Bks. Mo. Date signed 10/4/48

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

SEP 23 1953

JUL 20 1949

MAY 18 1949

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 me

..... Registered Apprentice No. .....

working under my personal supervision.

Signed Thomas M. Dobson

Licensed Embalmer No. 4479

P. O. Address St Louis, 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.