

FILED APR 27 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14196
Registrar's No. 3487

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 14196		Registrar's No. 3487		
1. PLACE OF DEATH a. COUNTY <u>St Louis - MO</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Ill</u> b. COUNTY <u>St Clair</u>					
b. CITY OR TOWN <u>St Louis MO</u>			c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>East St Louis - Ill</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Marys Infirmary</u>					d. STREET ADDRESS (If rural, give location) <u>275 - Exchange</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Georgia</u>			b. (Middle) _____		c. (Last) <u>Nicholson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 6-1951</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Feb-12-1895</u>		9. AGE (In years last birthday) <u>56</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Scobee - Miss.</u>			12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>		
13a. FATHER'S NAME <u>Walter H. Nicholson</u>			13b. MOTHER'S MAIDEN NAME <u>Georgia Nicholson</u>			14. NAME OF HUSBAND OR WIFE <u>John Nicholson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>John Hayes</u> ADDRESS _____					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____					<u>Cordone Jaundice</u>					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.					ANTECEDENT CAUSES					
					Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Surgical Shock</u>					
					DUE TO (c) <u>operation of Abdominal</u>					
II. OTHER SIGNIFICANT CONDITIONS					Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>4/6/51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Large Abdominal Inward Underlying Degeneration</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>2/1/51</u>						
22. I hereby certify that I attended the deceased from <u>3/15/51</u> , to <u>4/6</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4/6/51</u> , 19 <u>51</u> , and that death occurred at <u>9:15</u> m., from the causes and on the date stated above.										
23a. SIGNATURE <u>Edey F. Woodson</u> (Degree or title) <u>MD</u>					23b. ADDRESS <u>930 N. 2nd St St Louis</u>			23c. DATE SIGNED <u>4/10/51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>Apr 15-1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Douglass</u>		24d. LOCATION (City, town, or county) (State) <u>St Clair Co, Ill</u>				
DATE REC'D BY LOCAL REG. <u>APR 14 1951</u>		REGISTRAR'S SIGNATURE <u>J. B. Laska</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>A. N. Officer</u> ADDRESS <u>2144 - Mo. Ave</u>					

WRITE PLAINLY—USING 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 me

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Ben. H. Baldwin

Licensed Embalmer No. 2420

P. O. Address East St. Louis

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.