

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30422

State File No. ....

No. 300  
10-48

FILED SEP 8-1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2149

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

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Koch, Mo.</b>		c. LENGTH OF STAY (In this place) <b>13 mos.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Koch Hospital, Koch, Mo.</b>		c. CITY: (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> 2219	
		d. STREET ADDRESS (If rural, give location) <b>2309 Dickson</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Isiah</b> b. (Middle) <b>Howard</b> c. (Last) <b>Nichols</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Aug 10, 1952</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>May 22, 1894</b>		9. AGE (In years last birthday) <b>58</b>		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					

13a. FATHER'S NAME <b>John Nichols</b>		13b. MOTHER'S MAIDEN NAME <b>Nettie Appleton</b>		14. NAME OF HUSBAND OR WIFE <b>Mattie Nichols</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>336-09-4747</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Records Koch Hospital, Koch, Mo.</b>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Pulmonary Tuberculosis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>002X</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 7-10, 1951 to 8-10, 1952, that I last saw the deceased alive on 8-10, 1952 and that death occurred at 4.15 m., from the causes and on the date stated above.

23a. SIGNATURE <b>Dr. Davis M.D.</b> (Degree or title)		23b. ADDRESS <b>Koch Hospital, Koch, Mo.</b>		23c. DATE SIGNED <b>8-11-52</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>8-16-52</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
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DATE REC'D BY LOCAL REG. <b>8-14-52</b>		REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ellis Funeral Home 2820 Stoddard</b>	
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**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*James A. Carter*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

*4681*

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.