

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6621**

FILED MAR 8 1954 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1759**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Missouri b. COUNTY Warren	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN Vienna	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		e. STREET ADDRESS (If rural, give location) unknown 0630	

3. NAME OF DECEASED (Type or Print) LOYD	a. (First)	b. (Middle) O.	c. (Last) NICHOLS	4. DATE OF DEATH (Month) (Day) (Year) 2-21-54
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 11-14-1899	9. AGE (In years) (Month) (Days) (Hours) (Min.) 54
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) banker	10b. KIND OF BUSINESS OR INDUSTRY banking	11. BIRTHPLACE (City and State or Foreign Country) Dixon, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John W. Nichols	13b. MOTHER'S MAIDEN NAME Flora Burrough	14. NAME OF HUSBAND/ OR WIFE Mae Nichols
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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) no	16. SOCIAL SECURITY NO. 497-09-8533	17. INFORMANT'S SIGNATURE OR NAME Louise King,	ADDRESS 3816 Gustine
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Emphysema. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 minutes
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 1/25/54 2/18/54	19b. MAJOR FINDINGS OF OPERATION Confirmed above	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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? 518X

22. I hereby certify that I attended the deceased from **1/14**, 1954, to **2/21**, 1954, that I last saw the deceased alive on **2/20**, 1954, and that death occurred at **6:45 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James L. Mudd M.D.	23b. ADDRESS 634 N. Grand St. Louis 32d	23c. DATE SIGNED 2/23/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 2-21-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Vienna, Mo.
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DATE REC'D BY LOCAL REG. FEB 24 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Birmingham	ADDRESS F.H., Vienna, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No. working under my personal supervision.:

Student.....
Signature of Student Embalmer

Signed..... *J. Allen Davis*

Licensed Embalmer No. *4*

P. O. Address *St. L.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.