0.300
0.48

FILED JUL 19 1954

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23601

BIRTH NO. _____ REG. DIST. NO. 183 PRIMARY REG. DIST. NO. 4296 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY: Linn
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Browning
c. LENGTH OF STAY (in this place): 80 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Linn
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Browning 0580
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last): William Perry Nickell

4. DATE OF DEATH (Month) (Day) (Year): 7-5-54

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 11-7-1866
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months 8, Days 2 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Browning - Mo
12. CITIZEN OF WHAT COUNTRY?: US

13a. FATHER'S NAME: M. R. F. Nickell
13b. MOTHER'S MAIDEN NAME: Nancy R. Robinson
14. NAME OF HUSBAND OR WIFE: Lellia Carter Idead

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.: —
17. INFORMANT'S SIGNATURE OR NAME: Cecil Dodson — ADDRESS: Browning

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 332 X
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1952, *to* July 5, 1954, *that I last saw the deceased alive on* July 5, 1954, *and that death occurred at* 4:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Howard Carter M.D.
23b. ADDRESS: Browning Mo
23c. DATE SIGNED: July 7, 1954

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-7-54
24c. NAME OF CEMETERY OR CREMATORY: White Oak Cem
24d. LOCATION (City, town, or county) (State): Sullivan Co Mo

DATE REC'D BY LOCAL REG.: July 15, 54
REGISTRAR'S SIGNATURE: Elva Crookshank 166-
25. FUNERAL DIRECTOR'S SIGNATURE: Richard Dwight Schoene — ADDRESS: Milan Mo

(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 .....
Student Embalmer

Signed Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Milan Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.