

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2330

FILED FEB 13 1958

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 278 PRIMARY REG. DIST. NO. 3054 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Louisiana</u>		c. LENGTH OF STAY (In this place) <u>Annada</u>	c. CITY OR TOWN <u>Annada</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pike County Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>MONROE</u> b. (Middle) <u>Ephraim</u> c. (Last) <u>Nichols</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 6, 1958</u>	

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 14, 1892</u>	9. AGE (In years last birthday) Months Days Hours Min. <u>65</u>
10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) / <u>Dallas City Tex</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	

13a. FATHER'S NAME <u>Berjamin Nichols</u>	13b. MOTHER'S MAIDEN NAME <u>Ida Todd</u>	14. NAME OF HUSBAND OR WIFE <u>Cathrine Nichols</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>498-03-5749</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Cathrine M. Nichols Annada, Mo</u>

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		19. INTERVAL BETWEEN ONSET AND DEATH
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized carcinomatosis.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>carcinoma of colon which was resected--re-current.</u> DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1538</u>		

12-21-56 Resection of colon	13. DATE OF OPERATION <u>1-30-58</u>	14. TYPE OF OPERATION <u>Ileostomy --- re-current.</u>	15. ADENOCARCINOMA OF COLON <u>Adeno-carcinoma of colon</u>	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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?

22. I hereby certify that I attended the deceased from 12-14-56, 1956, to 2/6/58, 1958, that I last saw the deceased alive on 2/6/58, 1958, and that death occurred at 2:45P m., from the causes and on the date stated above.

25. SIGNATURE (Degree or title) <u>Bernice Callier M.D.</u>	23b. ADDRESS <u>Louisiana, Missouri</u>	23c. DATE SIGNED <u>2/7/58</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb. 8, 1958</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>
24d. LOCATION (City, town, or county) (State) <u>Clarksville Missouri</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. Brown, Clarkville Missouri</u>	

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

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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..

Student.....  
Signature of Student Embalmer

Signed *W. H. Brown*.....

Licensed Embalmer No. *2648*

P. O. Address *Clarksville*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.