

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000654

FILED VS FEB 15 1960 59

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 33 STATE FILE NUMBER \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cass</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Peculiar</u> Length of stay in lb <u>1 mo. 25 day</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u> c. CITY OR TOWN <u>Garden City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pleasant View Rest Home</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			

<b>3. NAME OF DECEASED</b> (Type or print) First <u>Thomas</u> Middle <u>Henry</u> Last <u>Nicholson</u>			<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>3</u> Year <u>1960</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7/28/1866</u>	<b>9. AGE</b> (last birthday) <u>93</u>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Lynxville, Wisconsin</u>		
<b>13a. FATHER'S NAME</b> <u>Frederick L. Nicholson</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Annie E. Vanamburg</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Effie J. Nicholson</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> Address <u>Mr. H. L. Nicholson Creighton, Mo.</u>		

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____			
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	

**21. I attended the deceased from** NOVEMBER 1959 and last saw him alive on FEB 2 1960  
 Death occurred at 8 AM on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>J. Meedy MD</u>		<b>22b. ADDRESS</b> <u>HARRISONVILLE Mo</u>		<b>22c. DATE SIGNED</b> <u>2-5-60</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>2/6/1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Garden City Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Garden City, Missouri</u>
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Robinson - Lusk Garden City, Mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>Feb 5 - 1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs Ray Sebee</u>	

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *William J. Hickey*

Licensed Embalmer No. 4685

P. O. Address Garden City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.