URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUN 7 1960

ENDED

Registration District No. 2 Primary Registration District No. 5017 Registrar's No. 34

60-018215
STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY Andrew
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Savannah NODAWAY TWP.
Length of stay in 1b 18 MOS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1 Mile EAST of SAVANNAH
Inside Limits Yes ☐ No ☑

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY ANDREW
c. CITY OR TOWN SAVANNAH
Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) 1 MILE EAST
Reside on Farm Yes ☑ No ☐

3. NAME OF DECEASED (Type or print) First JOHN Middle FRANKLIN Last NICHOLSON
4. DATE OF DEATH Month MAY Day 28 Year 1960
5. SEX MALE
6. COLOR OR RACE WHITE
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH 2-26-1867
9. AGE (last birthday) 93
IF UNDER 1 YEAR Months Days
IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY FARMING
11. BIRTHPLACE (City and state or country) SALEM, INDIANA
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME WILLIAM NICHOLSON
13b. MOTHER'S MAIDEN NAME MALINDA JOHNSON
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT OTHA NICHOLSON, Address SAVANNAH, MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
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. ☐ Yes ☐ No ☐ Unknown

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

21. I attended the deceased from July 1, 1957 to May 28, 1960 and last saw ~~alive~~ him alive on May 28, 1960
Death occurred at 6:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. F. Sweeney (Degree or title) M.D.
22b. ADDRESS Oregon, Mo
22c. DATE SIGNED 5/29/60.

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 5-30-1960
23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY
23d. LOCATION (City, town, or county) HOLT COUNTY (State) MO
24. FUNERAL DIRECTOR JAMES H. CRAWFORD ADDRESS MOUND CITY, MO
25. DATE RECD. BY LOCAL REG. 6-4-60
26. REGISTRAR'S SIGNATURE Lillian Sparks

(Licensed Embalmer's Statement on Reverse Side)

JUN 17 1960

**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 James H. Pettijohn

Licensed Embalmer No. 3192

P. O. Address Oregon 7

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