

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-016472

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 156 Primary Registration District No. 200 Registrar's No. 238

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0499

2 0499

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Jasper | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Joplin | | Length of stay in 1b 55 yrs | c. CITY OR TOWN Joplin Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3330 Jackson Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First MELLIE Middle NICHOLS Last NICHOLS | | 4. DATE OF DEATH Month MAY Day 1 Year 1963 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4-12-1872 |
| 9. AGE (last birthday) 91 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) St. James, Mo. |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME John R. Brown | |
| 13b. MOTHER'S MAIDEN NAME Jamima Luster | | 14. NAME OF HUSBAND OR WIFE Dec'd Rolland J. Nichols, 7-10-60 | |
| 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 Dau- | | Address Mrs. Anna Doyle, 811 W. 34th St., Joplin | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric hemorrhage | | | INTERVAL BETWEEN ONSET AND DEATH 10 hrs |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Sensibility | | | 5 years |
| DUE TO (c) Bleeding | | | |
| 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 |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 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 11-20-58 , to 5-1-63 and last saw her alive on 5-1-63 . Death occurred at 8 Am on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Lucretia H. Ferguson M.D. | | 22b. ADDRESS Joplin, Mo. 201 Medical Arts Bldg. | 22c. DATE SIGNED 5-2-63 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 5-4-1963 | 23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY, | 23d. LOCATION (City, town, or county) JOPLIN, MISSOURI |
| 24. FUNERAL DIRECTOR STEVE PARKER MORTUARY, | | ADDRESS JOPLIN, MISSOURI | 25. DATE RECD. BY LOCAL REG. 5-4-1963 |
| | | 26. REGISTRAR'S SIGNATURE Dove Merriam | |

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

Hewey E. Linn

Licensed Embalmer No. 4463

P. O. Address Spokane, Wa.

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.