

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

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6467

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St Louis mo (No. Barnes Hospital)

File No.

Registered No. 1377

St. Ward)

2. FULL NAME

(a) Residence. No. 901 E Cherokee St., 12 Ward.

(Usual place of abode) Enid Okla

(If nonresident give city or town and State)

How long in U.S., if of foreign birth? yrs. mos. da.

Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 23, 1904

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
23 4 13

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Bank Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) in Bank
(c) Name of employer not employed

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas

10. NAME OF FATHER B. C. Nelson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

12. MAIDEN NAME OF MOTHER Katie Partney

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

14. INFORMANT Ethel Cochran
(Address) 929 East Oklahoma av.

15. FILED Enid Okla REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-6-1928

17. I HEREBY CERTIFY, That I attended deceased from 2-5-1928 to 2-6-1928, 1928 that I last saw him alive on 2-6-1928 and that death occurred, on the date stated above, at 2-10-1928

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Death of Brain
Infection of Right Lung leading
Pneumonia (duration) yrs. mos. da. 8
CONTRIBUTORY Death of Lung (SECONDARY) (duration) yrs. mos. da. 8

18. WHERE WAS DISEASE CONTRACTED Enid Okla
IF NOT AT PLACE OF DEATH?

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Paul D. Haughen, M. D.
1228 (Address) Dayton Missouri

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Enid Okla DATE OF BURIAL Feb 9 1928

20. UNDERTAKER Philander C. Craig ADDRESS 1446 S. Washington

N. B.—Every item of information should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH

State of ... that it may be properly carried out. ...

[The main body of the document contains several paragraphs of text that are extremely faint and largely illegible due to the quality of the scan. The text appears to be a formal report or memorandum.]

SECRET

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION REQUESTED
HEREON MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 791 File No.
Township..... Primary Registration District No. 1003 Registered No. 1277
City St. Louis (No.) St. Ward)

2. FULL NAME

Luther C. Nelson
(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 23 - 1904

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

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REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-6-28 19 28

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw him 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Abcesses of Brain due to abcess of Lung non Tubercular

CONTRIBUTORY (SECONDARY) Infection of Rt Lung following pneumonia Abcess of Lung due to Robar Pneumonia non Tubercular (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Information given over Phone by Dr. P. H. Chambers M.D. of St. L. 4-6-28
DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? 1010
(Signed) M. D.
19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

PERMANENT RECORD

PHYSICIAN'S should state
cause of OCCUPATION is very important

SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

REV

