

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

Do not use this space.

555

1. PLACE OF DEATH

County Carroll
Township Eugene
City 9 (No. 9)

Registration District No. 135
Primary Registration District No. 5201

File No. _____
Registered No. 5
St. _____ Ward _____

2. FULL NAME

William J. Nelson
(a) Residence No. _____ St. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ms w m g Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-22-1863

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
65 | 5 | 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Carroll Co mo
(STATE OR COUNTRY)

10. NAME OF FATHER James Wilson

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Lucretia Nelson
(Address) Wakonda mo

15. Filed 1-16 1929 Mrs. E. E. Farnham
REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-15 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-1-28 1928 to 1-15 1929
that I last saw him alive on 1-15 1929 and that death occurred, on the date stated above, at 7:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr Cardio Valvular Disease

926 926 (duration) 4 yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) 926 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) H. B. Dreyer M. D.

1-16 1929 (Address) Carrollton, Mo

*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 Walnut Grove Cur DATE OF BURIAL 1-17 1929

20. UNDERTAKER Wells Bros ADDRESS Carrollton mo

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

WRITE PLAINLY, WITH OBTAINING INFORMATION TO A MINIMUM EXTENT

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