

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

Do not use this space.

21657  
2797

**1. PLACE OF DEATH**

County Jackson Registration District No. 359  
Township Kaw Primary Registration District No. 1002  
City Kaw (No. Mercy Hospital)

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Roy Dean Nelson  
Cleveland Mo St. \_\_\_\_\_ Ward \_\_\_\_\_

(a) Residence. No. \_\_\_\_\_ (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) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 31-29

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
4 14

**8. OCCUPATION OF DECEASED**

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

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

10. NAME OF FATHER Wm Nelson

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

12. MAIDEN NAME OF MOTHER Elsie Froze

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

14. INFORMANT Record clerk  
(Address) Mercy Hospital

15. FILED 6/25 1929 M. M. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1929

17. I HEREBY CERTIFY, That I attended deceased from June 11 1929 to June 25 1929 that I last saw h. m. alive on June 25 1929, and that death occurred, on the date stated above, at 9:35 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Congenital Heart Disease  
1512  
159 (duration) yrs. 5 mos. 5 ds.

CONTRIBUTORY (SECONDARY) Malnutrition (duration) yrs. 6 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH Home

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Chemical Exms  
(Signed) J. M. Brewer M. D.

6/25 1929 (Address) Mercy Hospital

\*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**

Cleveland Mo

**DATE OF BURIAL**

6-25 - 1929

**20. UNDERTAKER**

Myers Undertaking

**ADDRESS**

Cleveland Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

