JUN. 5 1930

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

15719

1. PLACE OF DEATH

County: Crawford Co Mo — Registration District No. 1113 — File No.

Township: Osage — Primary Registration District No. 5317 — Registered No.

City: Huzzah — (No. ..... St. ..... Ward)

2. FULL NAME John 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 0 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Noisy

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 0

7. AGE: Years 77 — Months 0 — Days 0 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): 0
(c) Name of employer: 0

9. BIRTHPLACE (CITY OR TOWN): Jackson Co
(STATE OR COUNTRY): Tennessee

PARENTS

10. NAME OF FATHER: Bob Nelson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Jackson Co
(STATE OR COUNTRY): Tennessee
12. MAIDEN NAME OF MOTHER: Jane Nelson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Jackson Co
(STATE OR COUNTRY): Tennessee

14. INFORMANT: Don Gillam
(Address): Huzzah Mo

15. FILED 6-9, 1930 E. E. Seltz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 5/15 1930

17. I HEREBY CERTIFY, That I attended deceased from 5/12, 1930, to 5/12, 1930 that I last saw him alive on 5/12, 1930, and that death occurred, on the date stated above, at 4 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Diabetes Complicated with Bite Venomous

59
1328

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? 0 DATE OF 0

WAS THERE AN AUTOPSY? 0

WHAT TEST CONFIRMED DIAGNOSIS? Degeneration of the Kidneys

(Signed) J. C. Mincher, M. D

, 19 (Address) Viburnum 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Abbot Center Goodwater Mo — DATE OF BURIAL: May 17 1930

20. UNDERTAKER: Will Bayer — ADDRESS: Huzzah 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 UNFADING INK—THIS IS A PERMANENT RECORD

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CERTIFICATE OF DEATH

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County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. ..

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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 .....

(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)

PARENTS

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.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEA

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I HEREBY CERTIFY, That I attended dece
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that I last saw h..... alive on.....
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address).

*State the DISEASE CAUSING DEATH, or in deaths from (1) MEANS AND NATURE OF INJURY, and (2) whether Ac HOMICIDAL. (See reverse side for additional space.)

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