

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PUBLIC RECORD

FEB 16 1934
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.

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

Do not use this space.

1236

209

1. PLACE OF DEATH Stellam
County Howe Registration District No. 808
Township Howe Primary Registration District No. 808
City Kansas City Mo (No. Research Hospital) St. Ward
2. FULL NAME Ada B. Nelson
(a) Residence, No. 811 Troost 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED; WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF L. O. Nelson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-8-1875
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
58 9 7
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Renova Penn
13. NAME John Stout
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Renova Penn
15. MAIDEN NAME Lillie Martin
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bridges Penn
17. INFORMANT L. O. Nelson (ADDRESS) 811 Troost
18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Kas. DATE 1/17
O. V. MAST FUNERAL HOME, INC.
19. UNDERTAKER 3146 Main St (ADDRESS)
20. FILED Jan 15, 1934 7:27 a.m. Grove Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 15, 1934
22. I HEREBY CERTIFY that I attended deceased from Jan 10, 1934, to Jan 15, 1934.
I last saw her alive on Jan 15, 1934. Death is said to have occurred on the date stated above, at 3:10 a. m.
The principal cause of death and related causes of importance were as follows:
Streptococcus Septicemia Date of onset
10:15 AM
11:15 AM
Other contributory causes of importance:
Influenza
Pneumonia
Name of operation none Date of
What test confirmed diagnosis? Positive Blood Culture Was there an autopsy? NO
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury , 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury
24. Was disease or injury in any way related to occupation of deceased? NO
If so, specify San Roberts M. D.
(Signed) (Address) 1110 Prof. Bldg.

Mr Sam Roberts

Professor Bedy

365

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Vectn 4613

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Smith Home.
at Minneapolis Kas.

#2

DEPARTMENT OF COMMERCE

E. T. McCaugh, M. D.,
Special Agent,
Jefferson City, Mo.

BUREAU OF THE CENSUS

WASHINGTON

1236

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Kansas City

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Ada B Nelson*
Who died at _____ on *Jan 15 - 1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex *F* Color or race *W* Single, married, widowed or divorced: _____

Date of birth _____ Age: Years *58* Months *9* Days *7*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) *Strep. - Septuenna*
Birthplace of father (State or country) _____
Birthplace of mother (State or country) *Brnako*
Principal cause of death: *Tonsillitis - Pneumonia*

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____
Signature of Registrar *Sam E Roberts* Date filed *1/15/34*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. N. _____

Primary Reg. Dist. N. _____

Very truly yours,

E. T. McCaugh M.D.
eyc

Special Agent.

S-1136

1954 11/11/36

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