

DEC'D AUG 18 1939

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

26037

Do not use this space.

## 1. PLACE OF DEATH

(a) County Knox Registration District No. 447  
 (b) Township Burton Primary Registration District No. 5607  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 37 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Margaret Lillian Nelson  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 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 Claud Nelson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 2-1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
63 13 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife  
 9. Industry or business in which work was done, as 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) Staffersville Mo. C13. NAME Thomas H. Claggett14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Staffersville Mo.15. MAIDEN NAME Harriett Stone16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Peru Ky.17. INFORMANT (ADDRESS) Claud Nelson  
partly m18. BURIAL, CREMATION, OR REMOVAL PLACE Drewarts DATE 2-17 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) Keith Hudson  
Edna Mo20. FILED July 30 1939 Mrs. C. M. Smith 395 (Address) Knox City Mo  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 15 193922. I HEREBY CERTIFY, That I attended deceased from Feb 12 1939, to Feb 15 1939I last saw him alive on Feb 15 1939. Death is said to have occurred on the date stated above, at 9:30 a.m.

The principal cause of death and related causes of importance were as follows:

ApoplexyDate of onset  
2/12/39

Other contributory causes of importance:

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_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?  
If so, specify \_\_\_\_\_(Signed) Paul M. Reynolds \_\_\_\_\_, M. D.  
395 (Address) Knox City 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.

RECEIVED

District Health Officer No. 10

District File Number \_\_\_\_\_

Date Filed AUG 15 1939 \_\_\_\_\_

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Keith Hudson*

Licensed Embalmer No. \_\_\_\_\_

*2415*

P. O. Address \_\_\_\_\_

*Edina Mo...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.