

APR 23 1940

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

11895
Do not use this space.

1. PLACE OF DEATH

(a) County Oregon Registration District No. 632
(b) Township 2 Primary Registration District No. 4382 Registered No. 8
(c) City Thayer (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

425 Sarah Elizabeth Nelson
(a) Residence, No. Thayer 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 <u>Fe</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <u>Thomas Nelson</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct-18-1866</u>		
7. AGE YEARS <u>85</u>	MONTHS <u>4</u>	DAYS <u>23</u>
IF LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Retired</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Housework</u>	
	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) <u>Fulton Co. Ark. 1</u>		
FATHER	13. NAME <u>Lafate Hall</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tenn 1</u>	
MOTHER	15. MAIDEN NAME <u>Mary Jane Kyle</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown 9</u>	
17. INFORMANT <u>Mrs. John Edwards</u> (ADDRESS) <u>Thayer Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Garner Cem</u> DATE <u>3/12/40</u> 19.		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Rev. Park Thayer, Mo 513</u>		
20. FILED <u>Mar. 12 1940</u> <u>George Johnson</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 11 1940

22. I HEREBY CERTIFY That I attended deceased from March 10, 1940, to March 11, 1940
I last saw her alive on March 10, 1940 Death is said to have occurred on the date stated above, at 3:30 m.
The principal cause of death and related causes of importance were as follows:
Pneumonia
Other contributory causes of importance:
Chronic Hepatitis
Hypertension
Arteriosclerosis

Name of operation _____ 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) Michael Blaine, M. D.
(Address) Maumath Springs Ark

Date of onset
3-8
1940

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 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X16809

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.....

RECEIVED
working under my personal supervision
District Health Officer No. 5,

District File Number 4450 4447

Date Filed 4/11/50

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 632

Primary Registration District No. 4382

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Prange
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits write "RURAL")
(d) Street No.....
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME

Sarah Elizabeth Nelson

3. (b) If veteran,
name war.....

3. (c) Social Security
No.....

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married,
divorced wid

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if
alive..... year.....

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 4 23
h..... min.

9. Birthplace.....
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....
(City, town, or county) (State or foreign country)

14. Maiden name.....
(City, town, or county) (State or foreign country)

15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b).....
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 11
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
....., 19....., to....., 19.....;
that I last saw him..... alive on....., 19.....,
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Bronchial
Duration 3-7
1940

Due to.....

Due to Chr Nephritis

Other conditions Myocarditis
(Include pregnancy within 3 months of death)

Major findings: arthritis

Of operations.....

Of autopsy.....

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature Ditchell Blaine (M. D. or other)

Address Massachusetts Springs Signed W

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

11895- (1940)