

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 17368  
Registrar's No. 1895

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
K. C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 21 days  
In this community 1 yr. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Christine Nelson 425  
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Herman T. Nelson 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased Mar. 28th. 1857  
(Month) (Day) (Year)

8. AGE: Years 83 Months 1 Mo Days 16 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business  
12. Name Mohanson Olsen  
13. Birthplace Norway  
(City, town, or county) (State or foreign country)  
14. Maiden name UNKNOWN  
15. Birthplace ..  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Metcalf  
(b) Address Nichols, Iowa

17. (a) Burial (b) Date thereof 5/7/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Greenlawn Cemetery

18. (a) Signature of funeral director [Signature]  
(b) Address 2315 Linwood Blvd.

19. (a) May 6, 1940 (b) M. Th. Crown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2415 Anderson  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 4th  
year 1940 hour 6 minute 15A. M.

21. I hereby certify that I attended the deceased from 4-13-40, 19  , to 5-4-40, 19  ;  
that I last saw her alive on 5-4-40, 19  ;  
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of femur, right, accidental fall in home

Due to 1860  
Due to 15  
Other conditions Senility  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: None  
Of operations  
Of autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence about Apr 11 1940  
(c) Where did injury occur? Kansas City, Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
3101 While at work Home (Specify type of place) (e) Means of injury fall  
23. Signature R. H. De Marum M.D. (M. D. or other) fall  
Address Supt. K. C. Gen. Hospital, K. C. Mo Date signed

---

---

**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 R. E. Snow

Licensed Embalmer No. 2560

P. O. Address 2315 Linwood

**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.**