

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.

SEP 1 1940

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

28066
Do not use this space.

1. PLACE OF DEATH
 (a) County Butler Registration District No. 89
 (b) Township Poplar Bluff Primary Registration District No. 3007
 (c) City Poplar Bluff (d) Street No. _____
 (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 William Nelson
 (a) Residence, No. 722 Mary 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 male
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 23-1892

7. AGE YEARS 48 MONTHS 10 DAYS 8
 IF LESS than 1 day, hrs. or min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W.P.A. Worker
 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) Mississippi

FATHER
 13. NAME Nelson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER
 15. MAIDEN NAME unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT Addie Bee Nelson
 (ADDRESS) Poplar Bluff Mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Butte DATE Aug 5 1940

19. FUNERAL DIRECTOR (NAME) Frank Undertaking Co
 (ADDRESS) Poplar Bluff Mo

20. FILED 8/8 1940 Blutinger
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 31 1940

I HEREBY CERTIFY, That I attended deceased from July 27 at Mo, to July 31, 1940
 I last saw him alive on July 30, 1940. Death is said to have occurred on the date stated above, at 1:30 a m.
 The principal cause of death and related causes of importance were as follows:

Acute Cardiac failure 7/31/40
 Date of onset

Other contributory causes of importance:
Stomach 7/27/40
7/27/40

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 Accident Date of injury 7/13 1940
 Where did injury occur? Poplar Bluff Mo
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
Public place
 Manner of injury Blow to finger
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? Yes
 If so, specify Work - Public Works
 (Signed) J. W. Nichols M. D.
 (Address) Poplar Bluff Mo

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.....

Charles W. Green

Licensed Embalmer No.....

2964

P. O. Address.....

Capital Blvd. N

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28066
Registrar's No. 226

Registration District No. 89

Primary Registration District No. 3007

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

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Parlar Bluff
(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 _____ (Specify whether)
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 Wm Nelson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race col 6. (a) Single, wid, married, divorced Div

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

7. Birth date of deceased Sept. 28 1894
(Month) (Day) (Year)

8. AGE: Years 47 Months 10 Days 8 If less than one day _____ 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 _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 10/17/40 (b) Blusinger
(Date received local registrar) (Registrar)

DEATH CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1940 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

