JAN 25 1941

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

42361
Do not use this space.

1. PLACE OF DEATH
(a) County Dent — Registration District No. 1035
(b) Township Current — Primary Registration District No. 5371 — Registered No. 9
(c) City Montauk (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 James E Nelson
(a) Residence, No. " St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
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~~: Martha Nelson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): April 16, 1874
7. AGE: Years 66 — Months 7 — Days 15 — If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Saw Milling
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): Nov 1940
11. Total time (years) spent in this occupation: 50

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Montauk Mo.

FATHER
13. NAME: John W. Nelson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Dent County Mo

MOTHER
15. MAIDEN NAME: Nancy C. Bugman
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Dent County Mo

17. INFORMANT (ADDRESS): E. L. Dawson Lenox Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt Olive DATE 12-6 1940

19. FUNERAL DIRECTOR (ADDRESS): Smith & Ferguson Salem Mo

20. FILED 12/4 1940 J. A. Kissock Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 12-1 1940

22. I HEREBY CERTIFY, That I attended deceased from ✓, 19..., to ✓, 19...
I last saw h. ✓ alive on ✓, 19... Death is said to have occurred on the date stated above, at 2:40 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Apoplexy	Dec 1 1940
Duel Sequelle	30 Y

Other contributory causes of importance:
Chronic arterial hypertension has been ailing for past 2 yrs
Name of operation ✓ Date of ____
What test confirmed diagnosis? Autopsy was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No 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) Dr. Lieman Coroner M. D.
(Address) Salem Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

2 PM.

RECEIVED
District Health Officer No. 5,
District File Number 14130
Date Filed

STATEMENT BY LICENSED EMBALMER

I, Eubert E Ferguson, Licensed Embalmer No. 3945

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed Eubert E Ferguson

Licensed Embalmer No. 3945

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.)

No. 2B
-2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42361

Registration District No. 1035 Primary Registration District No. 5371 Registrar's No.

1. PLACE OF DEATH:
(a) County Dent
(b) City or town Current
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DEASCED:
(a) State MO. (b) County Dent
(c) City or town Current twp
(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 James E. Nelson
3. (b) If veteran name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
66	7	15	hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director J. Kirsock
(b) Address
19. (a) 12/4/1940 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 1 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

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 D. G. Dillon Co (M. D. or other)
Address Salem Mo Date signed

SUPPLEMENTARY