

APR 21 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

11389

Registration District No. 561Primary Registration District No. 3-75-6Registrar's No. 22

## 1. PLACE OF DEATH

(a) County Miller  
 (b) City or town Bagnell  
 (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 1 (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME WILLIAM GRANT HELSEL3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced  
 6. (b) Name of husband or wife Mamie 6. (c) Age of husband or wife if alive 68 years  
 7. Birth date of deceased May 3 1865  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>10</u>	<u>19</u>	hr. _____ min.

9. Birthplace Perre  
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Jersey Hessel13. Birthplace Perre  
(City, town, or county) (State or foreign country)14. Maiden name UK15. Birthplace UK 9  
(City, town, or county) (State or foreign country)16. (a) Informant Weyland Hessel(b) Address Steville, Mo.17. (a) Burial (b) Date thereof 3-  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Dorsey Phillips Funeral Home(a) Signature of funeral director B. H. H. H.(b) Address Belle Fourches19. (a) 3-26-1941 (b) Belle Fourches  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

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

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27  
year 1941 hour 8 minute 10 A.M.21. I hereby certify that I attended the deceased from March 4  
\_\_\_\_\_, 19\_\_\_\_, to March 27, 19\_\_\_\_  
that I last saw h. in alive on March 23, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Cardiac failureDue to Chronic Myocarditis

Due to \_\_\_\_\_

Other conditions Convalescing from Pneumonia  
(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? \_\_\_\_\_

495 (Specify type of place)

While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature E. Shelton MD (M. D. or other) \_\_\_\_\_Address Eldon Mo Date signed Mar 27

RECEIVED  
Miller County Health Dep't.  
County File Number 41-43  
Date Filed 41

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

Louis D Phillips, Registered Apprentice No. \_\_\_\_\_  
working under  personal supervision.

Signed Louis D Phillips

Licensed Embalmer No. 3663

P. O. Address Adrian

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11389

Registration District No. 561

Primary Registration District No. 5756

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Miller
- (b) City or town Wagnell  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Wm Grant Nelsel

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

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

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
	<u>75</u>	<u>10</u>	<u>19</u>	hr 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 (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)

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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 24 year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death Cardiac failure Duration \_\_\_\_\_

Due to Chr drug Carditis

Due to \_\_\_\_\_

Other conditions Convalescing from  
(Include pregnancy within 3 months of death)

Major findings: Pneumonia Lobar

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature E. Shelton MD (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-11389