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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 18 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21299

Registration District No. 104 Primary Registration District No. 3008 Registrar's No. 182

1. PLACE OF DEATH:
(a) County: Calloway
(b) City or town: Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 34yr. 3 Mo. 20d (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Cooper 14 1 2
(c) City or town: RURAL
(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.? D years.

3. (a) PRINT FULL NAME: Lillian Nelson
3. (b) If veteran, name war:
3. (c) Social Security No. D.K.

4. Sex: F 1
5. Color or race: W
6. (a) Single, widowed, married, divorced: widow
6. (b) Name of husband or wife: D.K.
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: D.K. (Month) (Day) (Year)

8. AGE: Years: D.K. Months: Days: If less than one day: hr. min.

9. Birthplace: America 1 (City, town, or county) (State or foreign country)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: D.K.
13. Birthplace: 9 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: D.K.
15. Birthplace: 9 (City, town, or county) (State or foreign country)
16. (a) Informant: Hospital Records
(b) Address: State Hosp. #1, Fulton
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 6 27 41 (Month) (Day) (Year)
(c) Place: burial or cremation: Columbia Mo
18. (a) Signature of funeral director: G. O. Roberts
(b) Address: Columbia Mo 106
19. (a) June 27, 1941 (Date received local registrar) (b) R. N. Crews (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: June day: 27 year: 1941 hour: 12 minute: 30 A.M.
21. I hereby certify that I attended the deceased from April 3, 1941, to June 27, 1941; that I last saw him alive on June 26, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar pneumonia	4 days
Due to: Chronic Myocarditis	
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: Katherine Shirley (M. D. or other) M.D.
Address: State Hospital #1 Date signed: 6-27-41

(Licensed Embalmer's Statement on Reverse Side) Fulton

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.....

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, fact should be so stated above.