DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 16 1942

Registration District No. 136

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4435

State File No. 7666

Registrar's No. 4847

1. PLACE OF DEATH:
(a) County: RANDOLPH
(b) City or town: CLARK (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 ____ In this community 38 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Randolph
(c) City or town: Clark (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: ELIZABETH NELSON
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: MARRIED
6. (b) Name of husband or wife: J. B. NELSON
6. (c) Age of husband or wife if alive: 52 years
7. Birth date of deceased: JAN. 12 - 1880 (Month) (Day) (Year)

8. AGE: Years 62 | Months 1 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace: MONROE Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: HWF.
11. Industry or business: /
FATHER
12. Name: WILLIAM TOMLINSON
13. Birthplace: / (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name: unknown
15. Birthplace: unknown (City, town, or county) (State or foreign country)
16. (a) Informant's own signature: J. B. Nelson
(b) Address: Clark, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 26 - 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: Chapel Hayes
18. (a) Signature of funeral director: Ramon Boots
(b) Address: Stanley, Mo.
19. (a) ✓ (Date received local registrar) (b) Irma Nave (Registrar's signature)
Mar. 7-1942

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24 year 1942 hour 9 minute P. M.
21. I hereby certify that I attended the deceased from Jan. 4, 1940, to Feb. 23, 1942 that I last saw h. alive on Feb. 23, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma

Due to:

Due to:

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

Major findings: Of operations:

Of autopsy:

Duration

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: Dr. Joseph H. Jones (M. D. or other) D.O.
Address: Stanley, Mo. Date signed: 3/2/42

(Licensed Embalmer's Statement on Reverse Side)

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.

JAN 2 1945

RECEIVED
District Health Officer No. 10
District File Number 10-42-364
Date Filed MAR 10 1942

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 A E Booth

Licensed Embalmer No. 4087

P. O. Address Sturgeon, Mo.

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.

. S. No. 2B
.0M—8-21-41
I X29288

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. 7600

Registration District No. 736 Primary Registration District No. 4435 Registrar's No.

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Clark
(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 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

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

4. Sex F
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 Jan (Month) 12 (Day) 1868 (Year)

8. AGE: Years 62 Months 1 Days (If less than one day) hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year 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 Carcinoma of mediastinum	
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

45d