

No. 2  
4-15-42  
5-17-42  
PI 12:36

13857

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 23 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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

Registration District No. \_\_\_\_\_

Primary Registration District No. 4-0605144

Registrar's No. 4

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

1. PLACE OF DEATH:  
(a) County Caldwell  
(b) City or town Rural Kingston Mo  
(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 \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Caldwell / 3  
(c) City or town Rural 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Albert William Nelson

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

4. Sex Male ( ) 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of ~~husband's~~ wife Zada E Nelson  
6. (c) Age of ~~husband's~~ wife if alive 49 years  
7. Birth date of deceased December 8 1890  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>4</u>	<u>24</u>	hr. _____ min. _____

9. Birthplace Guilford 0 Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

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

MOTHER FATHER {  
12. Name Robert Nelson  
13. Birthplace 4 Denmark  
(City, town, or county) (State or foreign country)  
14. Maiden name Maria Nelson  
15. Birthplace 5 Denmark  
(City, town, or county) (State or foreign country)

16. (a) Informant Zada E Nelson  
(b) Address Kingston Mo

17. (a) Burial (b) Date thereof May 4 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Kingston Cemetery

18. (a) Signature of funeral director Erasmus Clark  
(b) Address Kingston Mo

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2  
year 1942 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from April 2 - 1942  
1937, 19\_\_\_\_, to May 2, 1942  
that I last saw ~~him~~ alive on May 1, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Malignant Hypertension / acute nephritis

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations None  
Of autopsy None

Duration Not known 20 days  
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 Chas. W. Jones (M. D. or other) \_\_\_\_\_  
Address Rolla Mo Date signed 5-1-42

**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 Lester Clark

Licensed Embalmer No. 3257

P. O. Address Kingston 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1385-7

Registration District No. \_\_\_\_\_

Primary Registration District No. 5144

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

1. PLACE OF DEATH:

(a) County Caldwell  
 (b) City or town Rural  
(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)

3. (a) PRINT FULL NAME Albert W. 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 Dec. 8 - 1890  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (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 Mo (b) County Caldwell  
 (c) City or town Rural  
(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 May day \_\_\_\_\_  
 year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death malignant  
hypertension  
acute nephritis  
Following Chronic  
Nephritis. 4 years duration

Duration \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature E. H. Wilson (M. D. or other) \_\_\_\_\_

Address P.O. Box 700 Date signed \_\_\_\_\_

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

SUPPLEMENTARY

1318

