No. 2
-1-4-41
5-17-39
1 X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

JUL 25 1949

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

21923

State File No.

Registration District No. 632 Primary Registration District No. ~~5834~~ 4382 Registrar's No.

1. PLACE OF DEATH:

(a) County: Oregon

(b) City or town: Thayer 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)

In this community: 11 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Oregon 75

(c) City or town: Thayer 1
(If outside city or town limits, write "RURAL")

(d) Street No. 6
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country: O

3. (a) PRINT FULL NAME: John Calvin Nelson

3. (b) If veteran, name war: --

3. (c) Social Security No.: --

4. Sex: Male O

5. Color or race: White

6. (a) Single, married, widowed, divorced: Widowed

6. (b) Name of husband or wife: Mary Strong

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: March (Month) 18 (Day) 1874 (Year)

8. AGE:

Years	Months	Days	If less than one day
67	9	8	hr. min.

9. Birthplace: Ava (City, town, or county) Missouri O (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Sam Nelson
13. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant: George Nelson
(b) Address: Williford, Ark.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-27-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Thayer Cem.

18. (a) Signature of funeral director: Leo Carr
(b) Address: Thayer, Mo.

19. (a) 2-9-42 (Date received local registrar) (b) Joe D. Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26 year 1941 hour 10:00 minute A. M.

21. I hereby certify that I attended the deceased from Dec 22nd, 1941, to ..., 19..; that I last saw him alive on Dec 26, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to: Pneumonia	
Due to:	
Other conditions: Nephritis (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: H. B. Lloyd (M. D. or other)
Address: Mammoth Spring Ark. Date signed: 1-[illegible]

1112 (Licensed Embalmer's Statement on Reverse Side)

Hull

RECEIVED
District Health Officer No. 5,
District File Number 542379
Date Filed ~~7-4-2~~
7-24-42.

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

S. No. 2B
M—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. 21923

Registration District No. 632 Primary Registration District No. 4382 Registrar's No.

1. PLACE OF DEATH:

(a) County: Oregon

(b) City or town: Thayer
(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: John C 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: W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: Mar (Month) 18 (Day) 1874 (Year)

8. AGE: Years 67 Months 9 Days 8 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 Dec Day 26 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Nephritis Chronic
Pneumonia Lobar

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 H. S. Hull (M. D. or other)
Address Mammoth Spring, Ark. Date signed 8/17/42

SUPPLEMENTARY

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