

S. No. 2
M-9.4-41
Rev. 5-17-39
DOI X29484

26460

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **3234**

FILED SEP 3 1942 49
Registration District No. _____

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 days**
(Specify whether years, months or days)

In this community **32 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")

(d) Street No. **2804 Madison**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mrs. Mathilda Nelson**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Olaf Nelson**

6. (c) Age of husband or wife if alive **66** years

7. Birth date of deceased: **June 3 1872**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

70 2 24 hr. min.

9. Birthplace **Sweden**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **unk**

13. Birthplace **Sweden**
(City, town, or county) (State or foreign country)

14. Maiden name **unk**

15. Birthplace **Sweden**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Signe Lehman**

(b) Address **4447 Booth**

17. (a) **Burial** (b) Date thereof **8-31-1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Moriah Cemetery**

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **Kansas City, Mo.**

19. (a) **8-29-42** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **27** year **1942** hour **8** minute **45** M.

21. I hereby certify that I attended the deceased from **8/23** to **8/27** 19**42**

that I last saw him **in** alive on **8/27** 19**42** and that death occurred on the date and hour stated above.

Immediate cause of death **asthma**

Due to **myocarditis** Duration **5 days**

Due to **Hypertension** **93E** Duration **6 wks**

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

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy _____

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 **P. O. Connell** (M. D. or other) _____
Address **207 Victoria Bldg** Date signed **8/28-42**

361

(Licensed Embalmer's Statement on Reverse Side) **K.C. Mo**

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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 Clarence W. Chiles
Licensed Embalmer No. 3473
P. O. Address Le C. 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.