

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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

FILED SEP 15 1942

Registration District No. 862

Primary Registration District No. 6229

Registrar's No. 93

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

1. PLACE OF DEATH:

(a) County TEXAS  
(b) City or town Rural Sargent  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Dr. E. G. Cabool  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community all of life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Texas  
(c) City or town Rural Sargent  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 1  
year 1942 hour 7 minute 0 A. 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:  
Reyeurkage from Peptic ulcer  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Chr. Prostatitis  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 11/12

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence 1  
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 P. Lallihan (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME

Joshua Stevens 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, married  
6. (b) Name of husband or wife Fannie 6. (c) Age of husband or wife if 66 years  
7. Birth date of deceased March 3 1868  
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Douglas Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

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

MOTHER FATHER  
12. Name Samuel Nelson  
13. Birthplace unknown 7  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Davis  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. S. Nelson

(b) Address R. 43 Willow Springs

17. (a) Buried (b) Date thereof Aug 2, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sargent Cemetery

18. (a) Signature of funeral director Rayford V. Elliott

(b) Address Cabool Mo

19. (a) Aug 4/1942 (b) Mrs. Lon Miller  
(Date received local registrar) (Registrar's signature)

1237

Duration

15 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number 942872

Date Filed 9-14-42

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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.....

*Gaylord Velli*

Licensed Embalmer No. 22072

P. O. Address..... Cabool

**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.**