

No. 2
5-42
6-17-39
X32273

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9662**

LED APR 14 1943

Registration District No. **42** Primary Registration District No. **1000** Registrar's No. **36-2**

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **Saint Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days**
In this community **68 yrs. 3 mos. 17 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri**, (b) County **Buchanan**
(c) City or town **Saint Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **1102 Lincoln Street**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country **0**

3. (a) PRINTED FULL NAME **Emma Starrett Nelson**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **24th**
year **1943**, hour **3:00** minute **10a.m.**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Francis R. Nelson** 6. (c) Age of husband or wife if alive **70** years
7. Birth date of deceased **December 7th, 1874**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 3** 19**41** to **March 24** 19**43**
that I last saw her alive on **March 23** 19**43**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
68 **3** **17** hr. min.

Immediate cause of death:
arteriosclerosis, general anterior-cerebral heart and kidney disease
Due to **Coronary thrombosis - sudden death**
Duration **3-24-43**

9. Birthplace **Saint Joseph, Missouri**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **At Home**

11. Industry or business

PHYSICIAN
Major findings:
Of operations **1/3/43**
Of autopsy

MOTHER FATHER { 12. Name **Dallas Sterrett**
13. Birthplace **Unknown, North Carolina**
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name **Paralee Hall**
15. Birthplace **Saint Joseph, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Francis R. Nelson**
(b) Address **1102 Lincoln Street, St. Joseph**
17. (a) **Burial** (b) Date thereof **3/26/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

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?

(c) Place: burial or cremation **Mount Mora Cemetery**
18. (a) Signature of funeral director **W. Nelson**
(b) Address **319 So. 10th. Street, Home**
19. (a) **3-26-43** (b) **Rose Heigog**
(Date received local registrar) (Registrar's signature)

23. Signature **L. F. Serna M.D.** (M. D. or other)
Address **St. Joseph Mo** Date signed **3-24-43**
(Specify type of place) (e) Means of injury **0**

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

1233

(Licensed Embalmer's Statement on Reverse Side)

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 3/24/43

....., Registered Apprentice No.
working under my personal supervision.

Signed Frank A. Bowman

Licensed Embalmer No. 1710

P. O. Address St. Joseph 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.