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WHITE 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

24728
State File No.

LED JUL 30 1943
Registration District No. 94
Primary Registration District No. 3012
Registrar's No. 293

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 10 mos. 28 days (Specify whether years, months or days)
In this community: 10 mos. 28 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Louis
(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No.: 1515 N. Leffingwell
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

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3. (a) PRINT FULL NAME: Albert Nevels
3. (b) If veteran, name war: World War I
3. (c) Social Security No.: 333-03-2267
4. Sex: Male
5. Color or race: Colored
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: —
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: October 17, 1886 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
56	8	24	hr. min.

9. Birthplace: Columbia, Tennessee (City, town, or county) (State or foreign country)
10. Usual occupation: Chipper, Steel Foundry
11. Industry or business: " "
FATHER
12. Name: Vanus Nevels
13. Birthplace: Tennessee (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Ada Hoges,
15. Birthplace: Tennessee (City, town, or county) (State or foreign country)
16. (a) Informant: Hospital Records, Veterans Administration
(b) Address: Excelsior Springs, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 7-12-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Removed to Chicago, Ill.
18. (a) Signature of funeral director: HERBERT HOPE,
(b) Address: Excelsior Springs, Mo.
19. (a) 7-12-43 (Date received local registrar) (b) Mrs Sadie Redmond (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July day: 11 year: 1943 hour: 10:52 minute: P. M.
21. I hereby certify that I attended the deceased from August 13, 1942 to July 11, 1943; that I last saw him alive on July 11, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Tuberculosis, pulmonary, chronic, far advanced, active, bilateral	unknown
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Myocarditis with hypertrophy and right heart failure	unknown

Major findings:
Of operations:
Of autopsy: as shown above

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) (If means of injury)
23. Signature: FORREST G. BELL, M. D. (M. D. or other)
Address: Veterans Administration Excelsior Springs, Mo. Date signed: 7-12-43

1164
(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 7-29-43

JUL 21 1952

JUL 30 1968

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 James G. Moles.

Licensed Embalmer No. 3296.

P. O. Address Excelsior Springs

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.