

FILED FEB 24 1945
Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **ST. LOUIS**
(b) City or town **ST. LOUIS**
(c) Name of hospital or institution: **535 S. 23rd St. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: **10 1/2 yrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **17**
(c) City or town **ST. LOUIS**
(d) Street No. **535 S. 23rd St. 22**
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **EMMA NELSON**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **JIM NELSON** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **7 4 1879**
(Month) (Day) (Year)

8. AGE: Years **65** Months **9** Days **0** If less than one day hr. _____ min. _____

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

10. Usual occupation **DOMESTIC**

11. Industry or business _____

MOTHER FATHER
12. Name **ANDY GULLMAN**
13. Birthplace **Georgia**
14. Maiden name **EMMA SPICER**
15. Birthplace **Georgia**

16. (a) Informant **TERA JONES**
(b) Address **535 S. 23rd Street**
17. (a) ~~GREENWOOD~~ (b) Date thereof **2 10 1945**
(c) Place: burial or cremation **GREENWOOD**

18. (a) Signature of funeral director **Charles Birdie Howell**
(b) Address **2834 Cambridge**
19. (a) **FEB 9 1945** (b) **J. H. Deedel**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **4** year **1945** hour **12:40** minute **P** M.
21. I hereby certify that I attended the deceased from **July 3rd** **1944** to **Feb 4** **1945**
that I last saw her alive on **Feb 3rd** **1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Mitral Incompetency Bronchitis**
Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death) **92**

Major findings:
Of operations _____
Of autopsy _____

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 **0**
23. Signature **J. Deques** (M. D. or other)
Address **202 S. Jefferson** Date signed **2/8/45**

Duration **1 yr 4 mos**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 Chas. L. Howell

Licensed Embalmer No. 2452

P. O. Address 2834 Gamble

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.