V. S. No. 2
50M—9-4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

5714

State File No.

FILED MAR 12 1945

Registration District No. 77

Primary Registration District No. 3008

Registrar's No. 38

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

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: State Hosp. #1 No.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since Dec. 17-1934 (Specify whether)

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cooper Co.

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

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? ? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME OBC. Nelson

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex male

5. Color or race negro

6. (a) Single, widowed, married, divorced ? wid

6. (b) Name of husband or wife

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

7. Birth date of deceased ? (Month) ? (Day) ? (Year)

8. AGE: Years 85 | Months | Days | If less than one day ..... hr. ..... min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Reuben Nelson
13. Birthplace Va (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Margaret Braxton
15. Birthplace Va (City, town, or county) 1 (State or foreign country)

16. (a) Informant Hosp. records

(b) Address

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/3/45 (Month) (Day) (Year)

(c) Place: burial or cremation Boonville, Mo

18. (a) Signature of funeral director Stegner-Koenig

(b) Address Boonville Mo

19. (a) 2-3 1945 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

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MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 2nd day Feb. year 1945 hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from various stiff makes Dec 17, 1934, to Feb 2, 1945; that I last saw him alive on Feb 2, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocardiles

Due to Generalized arteriosclerosis marked

Due to 93th

Other conditions Senile mental changes
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy none granted

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. S. Tate (M. D. or other)

Address State Hosp. #1. Fulton Date signed 2-2-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 3-10-45

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 W. Stegner
Licensed Embalmer No. 3780
P. O. Address Boonville, 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.