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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 15436

FILED JUN 4 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4563

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**1. PLACE OF DEATH:**

(a) County St. Louis

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

(c) Name of hospital or institution: 4219 Randall Pl. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 4219 Randall Pl. (If rural, give location)

(e) Citizen of foreign country? May 22Nd (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Clarence W. Nelson

3. (b) If veteran, name war

3. (c) Social Security No. 488-07-2284

4. Sex Male

5. Color or race W.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alice Nelson

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Dec. (Month) 15th. (Day) 1879 (Year)

8. AGE: Years 65 Months 5 Days 7 If less than one day hr. min.

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

10. Usual occupation Blacksmith Helper

11. Industry or business Williams Patent Crusher Co. ago.

FATHER 12. Name ? Nelson

13. Birthplace (City, town, or county) Ky. (State or foreign country)

MOTHER 14. Maiden name Dont Know

15. Birthplace (City, town, or county) Ky. (State or foreign country)

16. (a) Informant Alice Nelson

(b) Address 4219 Randall Pl.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-45 (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Provost Und. Co.

(b) Address 3710 N. Grand Bl.

19. (a) MAY 23 1945 (Date received local registrar) (b) J. J. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 22nd. year 1945 hour 1.30 minute A. M.

21. I hereby certify that I attended the deceased from Apr-16-1945 May -22Nd 19 to 1945. 19; that I last saw him alive on May-22Nd-1945. 19; and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Chr-Bronchitis | ? |
| Chr-Emphysemia | ? |
| Chr- & Generalized Arterio-Sclerosis | ? |
| Due to Sec: Asthma Bronchial-Pul-Oedema- extremities- | |
| Due to Cardiac congestion & block- since last attack 3 to 4 Wks. | |

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No.

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 Illness,

(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 (M. D. or other)

Address 3716 Jennings Rd Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

## 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 Earl E. Proud

Licensed Embalmer No. 1578

P. O. Address 3710 N. Grand

**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.**