

FILED JUN 7 1945

Registration District No. 5945

Primary Registration District No. 4087

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Carter Co  
 (b) City or town van Buren  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
own Parent home  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community all life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Carter  
 (c) City or town van Buren mo  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_  
(Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Eveland Nelson  
 (b) If veteran, name war \_\_\_\_\_  
 (c) Social Security No. 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4  
 year 1945 hour 3 minute 45 AM.

4. Sex F  
 5. Color or race w  
 6. (a) Single, widowed, married, divorced single  
 (b) Name of husband or wife \_\_\_\_\_  
 (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov 29 1944  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 29 1945 to May 4 1945  
 that I last saw him alive on May 3 1945  
 and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months 4 Days 5  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Bronchial pneumonia  
 Duration 6 days

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

9. Birthplace van Buren mo  
(City, town, or county) (State or foreign country)

Other conditions MM  
(Include pregnancy within 3 months of death)

10. Usual occupation 0  
 11. Industry or business 0  
 12. Name John Bushong  
 13. Birthplace marion co. Ill!  
(City, town, or county) (State or foreign country)  
 14. Maiden name Delpha Burnham  
 15. Birthplace Carter Co mo  
(City, town, or county) (State or foreign country)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant John Bushong  
 (b) Address van Buren  
 17. (a) Burial (b) Date thereof May 5 45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation van Buren  
 18. (a) Signature of funeral director Leaton Jewett  
 (b) Address van Buren mo  
 19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_  
 23. Signature Frank J. Reinhardt (D. or other) Dr.  
 Address van Buren mo Date signed 5/5/45

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

008

**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 Body was not embalmed, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed: Seaton Pruitt  
Licensed Embalmer No. 2287  
P.O. Address Van Buren 7m

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 58

Primary Registration District No. 4087

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Carter  
 (b) City or town Van Buren  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community life  
years, months or days)

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

3. (a) PRINT FULL NAME Mary E. Nelson  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month May Day \_\_\_\_\_  
 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: 29 (Month) 19 (Day) 19 (Year)

Duration \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) May 5-1945 (b) Mrs. R. J. Smith  
(Date received local registrar) (Registrar's signature)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M, D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

16572