

No. 2
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22824

FILED JUL 3 1947
Registration District No. 1

Primary Registration District No. 3063

Registrar's No. 1406

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

1. PLACE OF DEATH:

(a) County ST. LOUIS COUNTY

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

(c) Name of hospital or institution: ST. LOUIS COUNTY HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 DAYS
(Specify whether years, months or days)

In this community 3 WEEKS

3. (a) PRINT FULL NAME CHARLES NELSON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 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 DEC. 31 1902
(Month) (Day) (Year)

8. AGE: Years 44 Months 4 Days 26 If less than one day hr. _____ min. _____

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

10. Usual occupation Unknown

MOTHER FATHER

11. Industry or business _____

12. Name CHARLES NELSON

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

14. Maiden name SALLY ADAMS

15. Birthplace WHITE COUNTY ILLINOIS
(City, town, or county) (State or foreign country)

16. (a) Informant PATIENT

(b) Address Belleme County Club - Normandy Anatomical Board

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof 6-10-47
(Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. Reister

(b) Address 3500 Rte 10

19. (a) JUN 30 1947 (Date received local registrar) J. F. Bruesch (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS CO

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

(d) Street No BELLRIEVE COUNTRY CLUB - BRIDGE RD.
(If rural, give location)

(e) NR foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 27 year 1947 hour 8 minute 12 P.M.

21. I hereby certify that I attended the deceased from MAY 16 1947 to MAY 27 1947 that I last saw him alive on MAY 27 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary insufficiency

Due to adhesive pericarditis

Due to 906

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

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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 Wm. C. Citchman (M. D. or nat.)
Address 601 DRENTWOOD BLVD. Date signed 16/6/47

MAR 30 1949

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 317 Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St Louis County
(b) City or town Clayton
(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 _____ 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

Charles Nelson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Dec 31 1901
(Month) (Day) (Year)

8. AGE: Years 41 Months 1 Days 2 (Less than one day) hr. _____ min. _____

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

10. Usual occupation Supervisor

11. Industry or business _____

MOTHER FATHER

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Conrad Shappert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____

Due to _____

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

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Supplemental

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

27824