

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

12796  
12030

State File No. \_\_\_\_\_

1518

Registration District No. 249

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 3318 Karnes Blvd.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 58 years  
years, months or days

3. (a) PRINT FULL NAME Mrs. Lola Belle Nelson

3. (b) If veteran, name war No. 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Burt H. Nelson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 5th, 1881  
(Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At Home

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

12. Name Robert S. Mann

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

14. Maiden name Susan E. Anderson

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

16. (a) Informant Mrs. Bertha N. Wright

(b) Address 3318 Karnes Blvd.

17. (a) Burial (b) Date thereof 4/9/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Missouri

19. (a) 4-8-48 (b) Geralline Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3318 Karnes Blvd. 8  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7th.  
year 1948 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 23  
1947, to April 7, 1948

that I last saw her alive on April 5, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure Duration 3 months.

Due to Generalized arteriosclerosis

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

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

Major findings: None 930

Of operations \_\_\_\_\_

Of autopsy None

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 (A)

23. Signature Blaine J. Hiltner (M. D. or other)  
Address 209 Plaza Tower Bldg. Date signed April 7, 48

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

MOTHER FATHER

*M. G. V. Bell*

*1:30 - 4*

*209 Please Stamp Body*

**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 *Walter H. Erwin*

Licensed Embalmer No. *4352*

P. O. Address *Hanson City, 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.**