

FILED OCT 6 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29026

Registration District No. 43

Primary Registration District No. 5135

Registrar's No. 324

1. PLACE OF DEATH:

(a) County BUTLER
(b) City or town BROSELY (RURAL)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ash Hill Twp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 2 yrs 1 (Specify whether years, months or days)

3. (a) PRINT FULL NAME TROVER C. NELSON

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MINNIE NELSON 6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased: OCT. 29 1880 (Month) (Day) (Year)

8. AGE: Years 67 Months 10 Days 3 If less than one day hr. min.

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

10. Usual occupation FARMING

11. Industry or business

12. Name SAM NELSON
13. Birthplace UNKNOWN INDIANA (City, town, or county) (State or foreign country)
14. Maiden name HARRIET WRIGHT
15. Birthplace INDIANA (City, town, or county) (State or foreign country)

16. (a) Informant TOM NELSON

(b) Address BROSELY RT 1 MO
(c) Place: burial or cremation HAZEL CEMETERY

17. (a) (Burial, cremation, or removal) (b) Date thereof 9-4-1948 (Month) (Day) (Year)

18. (a) Signature of funeral director LENTZ SERVICE
(b) Address KENNETH MO

19. (a) 9-29-48 (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BUTLER
(c) City or town BROSELY RT 1 (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 2 NO year 1948 hour 8 minute 25 AM.
21. I hereby certify that I attended the deceased from MAY 1 1948 to Aug 36 1948 that I last saw him alive on Aug 30 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Decompensated Heart.
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? _____ (Specify type of place) (e) Means of injury _____

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

23. Signature J.B. Salling M.D. (M. D. or other)
Address J.B. Salling MO Date signed Sept 14 1948

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

RECEIVED

District Health Office No. 2,

District File Number 1048-1254

Date Filed 10-1-48

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 Edgar Lee Ford
Licensed Embalmer No. 4433
P. O. Address Rennett, Va.

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.