

No. 300
-10-47
5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 29 1948
Registration District No. _____

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33215**
Registrar's No. **189**

Primary Registration District No. **5572**

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

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Rural Prairie**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Jackson Co. Emerg. Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days**
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Independence**
(If outside city or town limits write "RURAL")
(d) Street No. **1017 South Willis**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Elizabeth Nelson**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **no**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **16**
year **1948** hour **6:00** minute **p.** M.
21. I hereby certify that I attended the deceased from **10-6** 19**48**, to **10-16** 19**48**
that I last saw h. **er** alive on **10-16** 19**48**
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **wh**
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 **Aug 27 1875**
(Month) (Day) (Year)
8. AGE: Years **73** Months **1** Days **19** If less than one day hr. _____ min. _____

Immediate cause of death: **Bilateral atelectasis of lungs**
Recent ventral hernia
Duration _____

9. Birthplace **Hickory Co., Mo**
(City, town, or county) (State or foreign country)
10. Usual occupation **Home**

Due to _____
Other conditions **Obesity**
(Include pregnancy within 3 months of death) **yes**

MOTHER FATHER
11. Industry or business **"**
12. Name **James C Nelson**
13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Miller**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

Major findings: **Obesity**
Of operations _____
Of autopsy **As above**
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs Ethel Kesner**
(b) Address **40 S 8th St I.C.H.**
17. (a) **Parryville** (b) Date thereof **Oct 19 1948**
(Birth, cremation, or removal) (Month) (Day) (Year)
(c) Place, burial or cremation **Mapel Hill Cemetery I.C.H.**
18. (a) Signature of funeral director **Parryville Bros**
(b) Address **I.C.H.**
19. (a) **OCT. 19 1948** (b) **Donald C. Emswiler**
(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 _____
Signed **Frank E. Johnson, M.D.** (M. D. or other) _____
Address **Independence, Mo.** Date signed **10/16/48**

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..... *Francis Walter*

Licensed Embalmer No. *2744*

P. O. Address..... *1 C M D*

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.