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

FILED MAR 21 1949

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8135

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 238-A

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN: Rural—South Campbell Township
c. LENGTH OF STAY (in this place): 10 min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ozark Osteopathic

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Greene
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield
d. STREET ADDRESS (If rural, give location): 833 N. Nettleton

3. NAME OF DECEASED (Type or Print)
a. (First): Rosa
b. (Middle): M.
c. (Last): Nelson

4. DATE OF DEATH (Month) (Day) (Year): Mar. 11, 1949

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 12, 1879
9. AGE (In years on last birthday): 69 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nurse
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Charles F. Nelson
13b. MOTHER'S MAIDEN NAME: Ester V. McMillen
14. NAME OF HUSBAND OR WIFE: Single

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 499-10-8841
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Elizabeth Swisher
ADDRESS: Pitts. Kans.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 1 HR.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

4311

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JAN 2, 1949, *to* FEB 18, 1949, *that I last saw the deceased alive on* FEB 18, 1949, *and that death occurred at* 9:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Howard J. Mason D.O.
23b. ADDRESS: 700 E. Sunshine, Springfield Mo
23c. DATE SIGNED: 3-12-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial Removal
24b. DATE: 3-14-49
24c. NAME OF CEMETERY OR CREMATORY: Ft. Scott Cemetery
24d. LOCATION (City, town, or county) (State): Ft. Scott, Kansas

DATE REC'D BY LOCAL REG.: 3/14/49
REGISTRAR'S SIGNATURE: M E Hardy M.D.
25. FUNERAL DIRECTOR'S SIGNATURE: J.W. Klingner & Co.
ADDRESS: Spgfd. Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Student Embalmer No.....

working under my personal supervision.

Signed Max Rhodes

Signed.....
Student Embalmer

Licensed Embalmer No. 4071

P. O. Address Spring Hill

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.