

FILED MAR 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10883**
2197

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		a. STATE Missouri b. COUNTY Dent	
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Boss	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS (If rural, give location) 0330 1	

3. NAME OF DECEASED (Type or Print)	a. (First) Jesse	b. (Middle) Wilbur	c. (Last) Nelson	4. DATE OF DEATH (Month) (Day) (Year)
				March 6, 1950

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 29, 1889	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Boss, Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Marion Nelson	13b. MOTHER'S MAIDEN NAME Martha King	14. NAME OF HUSBAND OR WIFE Bessie B. Nelson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Bessie Nelson, Boss, Mo.	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 weeks " 10 mos. 30+ yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bacterial Endocarditis		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bruella Abortus DUE TO (c) Undulant Fever		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rheumatic Heart Disease			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2-24**, 19**50**, to **3-6**, 19**50**, that I last saw the deceased alive on **3-6**, 19**50**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE John L. Kennedy M.D. C.M.	(Degree or title)	23b. ADDRESS 508 No Grand	23c. DATE SIGNED 3-7-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-7-50	24c. NAME OF CEMETERY OR CREMATORY Boss	24d. LOCATION (City, town, or county) (State) Boss, Mo.
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DATE REC'D BY LOCAL REG. MAR 7 1950	REGISTRAR'S SIGNATURE J. B. Sasater	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Student
Student Embalmer

Signed *J. Wm Bursley*
Licensed Embalmer No. *3653*

P. O. Address *St Louis 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.