

9-18-
 FILED OCT 2 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

29497

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>42</u>	PRIMARY REG. DIST. NO. <u>1000</u>	Registrar's No. <u>1070</u>
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> <u>0117</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>2136 South 12th St.</u>		
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Anna</u>	b. (Middle) <u>Laura</u>	c. (Last) <u>Nelson</u>
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>
8. DATE OF BIRTH <u>Nov. 15, 1874</u>		9. AGE (In years last birthday) <u>75</u> 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) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Easton, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Patrick Quinlivan</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Kelley</u>
14. NAME OF HUSBAND OR WIFE <u>Peter D.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Peter D. Nelson 2136 So. 12th St.</u>		
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c): II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ✓		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Unknown</u> <u>331X</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) (Min.)		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 <u>Sept 18</u> , 19 <u>50</u> , to <u>Sept 20, 1950</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>50</u> , and that death occurred at <u>6:07 P.M.</u> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>John J. Byrnes M.D.</u>		23b. ADDRESS <u>St. Joseph</u>		23c. DATE SIGNED <u>9-22-50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-23-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>
24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>		DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE <u>Sept. 23, 1950</u> <u>G. B. Jenkins</u> <u>382</u>		
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Herman W. Sidenfaden</u> <u>1802 Union St.</u>				

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

0117
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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 Elmer Thomas.....

Signed.....
Student Embalmer

Licensed Embalmer No. 2640

P. O. Address St. Joseph, 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.