

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31779**
4120

FILED OCT 4 1952

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN North Kansas City	
c. LENGTH OF STAY (in this place) 1 wk		d. STREET ADDRESS (If rural, give location) 1217 Clay 94	
d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Lutheran			

3. NAME OF DECEASED (Type or Print) Artie Nelson			4. DATE OF DEATH (Month) (Day) (Year) 17 Sept. 1952		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 20 May 1899		9. AGE (In years last birthday) 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Homemaker	11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Ambrose D. Swan		13b. MOTHER'S MAIDEN NAME Alice B. Ector		14. NAME OF HUSBAND OR WIFE Torsten Nelson	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Torsten Nelson ADDRESS NK	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) General Peritonitis ANTECEDENT CAUSES Chronic Gastric Ulcer Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Perforation DUE TO (c) Perforation II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 54 hr
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **10** to **19**, that I last saw the deceased alive on **19**, and the death occurred on **17** m., from the causes and on the date stated above.

23a. SIGNATURE Jack H. Hill MD (Degree or title)		23b. ADDRESS 3001 W. Grand St. St. Louis		23c. DATE SIGNED 17 Sept 52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 19 Sept. 1952	24c. NAME OF CEMETERY OR CREMATORY I O O F Cemetery		24d. LOCATION (City, town, or county) (State) Smithville Mo.
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DATE REC'D BY LOCAL REG. 9-19-52		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE W. J. ... ADDRESS Funeral Home NK	
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WRITE PLAINLY—USING UNFAADING 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. 457

working under my personal supervision.

Student Robert Gene Page
Student Embalmer

Signed: James M. Brown

Licensed Embalmer No. 4856

P. O. Address Mt. Carmel

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.