

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **16652**FILED APR 16 1953
BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **1015**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Normandy		c. LENGTH OF STAY (in this place) 9 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Normandy Osteopathic Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2109	
		d. STREET ADDRESS (If rural, give location) 3915a St. Louis Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Lee b. (Middle) Vie c. (Last) Nelson		4. DATE OF DEATH (Month) (Day) (Year) 4 8 1953	
5. SEX Female	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid.	8. DATE OF BIRTH 6-4-63
9. AGE (In years last birthday) 89		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady	11. BIRTHPLACE (State or foreign country) Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Clothing	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Charles Vie		13b. MOTHER'S MAIDEN NAME Elizabeth Page	14. NAME OF HUSBAND OR WIFE George Nelson
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. Unknown	17. INFORMANT'S SIGNATURE OR NAME X Leo Nelson
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Ovary Carcinoma ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Metastasis of St. Brent DUE TO (c) Myocarditis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Inferiority of eye	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 170X YES <input type="checkbox"/> NO <input 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)		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 June , 19 51 , to April 8 , 19 53 , that I last saw the deceased alive on April 7 , 19 53 , and that death occurred at 4:00 a. m., from the causes and on the date stated above.			
23a. SIGNATURE Hofhaerman		23b. ADDRESS 200 8731 Riverview	23c. DATE SIGNED 4/8/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-8-53	24c. NAME OF CEMETERY OR CREMATORY Independence
24d. LOCATION (City, town, or county) (State) Independence Mo		25. FUNERAL DIRECTOR'S SIGNATURE Harbert R. Donohue MD Carson Funeral Home	
DATE REC'D BY LOCAL REG. 4-8-53		ADDRESS Carson Funeral Home	

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 Ronald O. Yahrke

Licensed Embalmer No. 13917

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.