

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19728**
Registrar's No. **4630**

FILED JUN 1 - 1953 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 township) OR TOWN St. Louis		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (in this place) Life		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2119 W 58 W Belle	

3. NAME OF DECEASED (Type or Print)	a. (First) Sonny	b. (Middle) Robert	c. (Last) Nelson	4. DATE OF DEATH (Month) (Day) (Year) May 5 1953
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH March 4, 1885	9. AGE (In years last birthday) Months Days 68 2 1	IF UNDER 1 YEAR Hours Mins.	IF SHOWN IN REG.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME Charles Nelson	13b. MOTHER'S MAIDEN NAME Mildred (?)	14. NAME OF HUSBAND OR WIFE --
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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. 490-015811	17. INFORMANT'S SIGNATURE OR NAME Mildred Matthews	ADDRESS Farmington, Mo. 215 S. Washington
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertension with Cerebrovascular Disease		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) Undetermined <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 334K
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22. I hereby certify that I attended the deceased from **4-21**, 19**53**, to **5-5**, 19**53**, that I last saw the deceased **alive on 5-5, 1953**, and that death occurred at **12:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edna E. Brooks, M.D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 5-5-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5/8/53	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Farmington, Missouri
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DATE REC'D BY LOCAL REG. MAY 7 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates	ADDRESS 4107 Finney Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4259

P. O. Address 4107 7

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.