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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32312

FILED SEP 30 1953

BIRTH NO. _____ REG. DIST. NO. 383 PRIMARY REG. DIST. NO. 5655 Registrar's No. 11

1. PLACE OF DEATH
a. COUNTY: Lawrence
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt. Vernon
c. LENGTH OF STAY (In this place): 132 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mo. State Sanatorium

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Dallas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buffalo 0300
d. STREET ADDRESS (If rural, give location): ✓

3. NAME OF DECEASED (Type or Print)
a. (First): Henry
b. (Middle):
c. (Last): Nelson

4. DATE OF DEATH (Month) (Day) (Year): Sept. 21, 1953

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3-26-96
9. AGE (In years last birthday): 57 — 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): Banker
10b. KIND OF BUSINESS OR INDUSTRY: Banking
11. BIRTHPLACE (City and State or Foreign Country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA
13a. FATHER'S NAME: Rube Nelson
13b. MOTHER'S MAIDEN NAME: Martha Stanley
14. NAME OF HUSBAND OR WIFE: Pearl Nelson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 492-03-5167
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: San. records, Mo. S.S., Mt. Vernon, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cor pulmonale — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Pulmonary tuberculosis, far adv. abt. 8 yrs.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 002X
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-11-53, 19___, *to* 9-21-, 19 53, *that I last saw the deceased alive on* 9-21, 1953, *and that death occurred at* 10:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C E Hellwig M. D.
23b. ADDRESS: Mt. Vernon, Mo.
23c. DATE SIGNED: 9-21-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 9-21-53
24c. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24d. LOCATION (City, town, or county) (State): Buffalo, Mo.

DATE REC'D BY LOCAL REG.: 9-22-53
REGISTRAR'S SIGNATURE: Earl Hendricks
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: R. B. Jones Buffalo Mo.

(Licensed Embalmer's Statement on Reverse Side)

OCT 8 1954

OCT 8 1954

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 Willis B. Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.