

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **45096**
6134

FILED 89410
JAN 22 1954

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) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Liberty - Rural	
c. LENGTH OF STAY (in this place) 7 hours		d. STREET ADDRESS (If rural, give location) Route 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION Conley Maternity Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) CRIS	b. (Middle) ALLEN	c. (Last) NELSON	4. DATE OF DEATH (Month) (Day) (Year) 11 - 24 - 53
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 11-24-53	9. AGE (In years last birthday) 7	IF UNDER 1 YEAR Months 19	IF UNDER 4 HRS. Hours 19	Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Leonard Thurman Nelson	13b. MOTHER'S MAIDEN NAME Maxine Luella Bellew	14. NAME OF HUSBAND OR WIFE None
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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. None	17. INFORMANT'S SIGNATURE OR NAME Maxine Nelson	ADDRESS Liberty, Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhagic Diathesis		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) Hemorrhage into Adrenals		
	DUE TO (c) Hemorrhage into Lungs		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Abruptio placentae			

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) (Min)	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 11-24, 1953, to 11-24, 1953, that I last saw the deceased alive 11-24, 1953, and that death occurred at 11:09 P.M., from the causes and on the date stated above.

23a. SIGNATURE Luther W. Swift	(Degree or title)	23b. ADDRESS 2105 Delap Ave	23c. DATE SIGNED 12-24-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11-25-53	24c. NAME OF CEMETERY OR CREMATORY K.C.C.O.S. Science Bldg.	24d. LOCATION (City, town, or county) (State) 2105 Indep. Ave. K. C., Mo.
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DATE REC'D BY LOCAL REG. 12-30-53	REGISTRAR'S SIGNATURE Sheldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE K. C. College of Osteopathy	ADDRESS K. C., Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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. . . .