

Health, Welfare Public Service

300 1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

FILED OCT 22 1956

STANDARD CERTIFICATE OF DEATH

30000 STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 951

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Greene		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		a. STATE Missouri		b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		Length of stay in 1b 15 years		d. STREET ADDRESS (If outside, give location) 516 E. Grand		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First WILLIAM		Middle RIELLY		Last NELSON		Month Day Year October 16 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1870	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Minister		10b. KIND OF BUSINESS OR INDUSTRY Ministry		11. BIRTHPLACE (City and state or country) Harrison, Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willian Nelson				14. MOTHER'S MAIDEN NAME Unknown			
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 Address Mrs May Nelson, Springfield, Mo.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction						1 hr	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						5yrs	
DUE TO (b) Arteriosclerotic heart disease with myocardial insufficiency							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 8-26-46 to 10-16-56 and last saw ^{her} _{him} alive on 10-16-56 Death occurred at 11:10 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) D. M. K. Lingner, M.D.				22b. ADDRESS 1630 N. Jefferson, Spfg., Mo.		22c. DATE SIGNED 10-17-56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 19, 1956		23c. NAME OF CEMETERY OR CREMATORY Greenlawn		23d. LOCATION (City, town, or county) (State) Springfield, Mo.	

24. FUNERAL DIRECTOR Jewell E. Windle		ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 10-19-56		26. REGISTRAR'S SIGNATURE Tavia Williamson	
---	--	------------------------------------	--	---	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Robert E. Muhlman*

Licensed Embalmer No. *491A*

P. O. Address *Springfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.