

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7961**

FILED MAR 19 1957

BIRTH NO. _____ REG. DIST. NO. **64** PRIMARY REG. DIST. NO. **4110** Registrar's No. **14**

1. PLACE OF DEATH a. COUNTY Chariton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Chariton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Salisbury		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Salisbury 0210	
d. FULL NAME OF HOSPITAL OR INSTITUTION 411 East 2nd St.		d. STREET ADDRESS (If rural, give location) 411 East 2nd Street.	

3. NAME OF DECEASED (Type or Print)	a. (First) Sophia	b. (Middle) Elizabeth	c. (Last) Nellesen	4. DATE OF DEATH (Month) (Day) (Year) March 13, 1957
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4-28-1882	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 YEAR Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) Abolt, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Ridderman	13b. MOTHER'S MAIDEN NAME Anne Buckman	14. NAME OF HUSBAND OR WIFE Gerhard Arnold Nellesen
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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. xx	17. INFORMANT'S SIGNATURE OR NAME Mr. Theodore Nellesen	ADDRESS Salisbury Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 Wk 2 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Embolism		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Arterio Sclerosis		
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 4201	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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 **March 9, 1957**, to **March 13, 1957**, that I last saw the deceased alive on **March 13, 1957** and that death occurred at **1015** from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)	23b. ADDRESS Salisbury Mo	23c. DATE SIGNED 3-14-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 3-16-1957	24c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery	24d. LOCATION (City, town, or county) (State) Salisbury, Mo
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DATE REC'D BY LOCAL REG. 3-14-57	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Chas B Winhelmeier	ADDRESS Salisbury Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 20 1957

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 Chas B Winhelmejer

Licensed Embalmer No. 3842

P. O. Address Salisbury, 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.