

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8828**
1028

FILED MAR 20 1957

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 Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 23 yrs		e. STREET ADDRESS (If rural, give location) 1924 Montgall	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #2			

3. NAME OF DECEASED (Type or Print) a. (First) Willa b. (Middle) Mae c. (Last) Nelson	4. DATE OF DEATH (Month) (Day) (Year) March 2, 1957
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 20th 1923	9. AGE (in years last birthday) 33	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress	10b. KIND OF BUSINESS OR INDUSTRY restaurant	11. BIRTHPLACE (City and State or Foreign Country) Jefferson City, Missouri	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME Seldern Garthright	13b. MOTHER'S MAIDEN NAME Hazel Samuels	14. NAME OF HUSBAND OR WIFE Arthur Nelson
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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. unknown	17. INFORMANT'S SIGNATURE OR NAME Marie Harris, aunt	ADDRESS 1924 Montgall
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subarachnoid and intraventricular hemorrhage.		
	2. Cerebral edema.		
ANTECEDENT CAUSES		DUE TO (b) _____	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS		Pulmonary congestion and edema.	
Conditions contributing to the death but not related to the disease or condition causing death.		33 0X	

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)	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 2-18-57, 19 , to 3-2-57, 19 , that I last saw the deceased alive on 3-2-57, 19 , and that death occurred at 8:00 A.m., from the causes and on the date stated above.

23a. SIGNATURE (Design or title) W. R. Peterson M.D.	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 3-4-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 3 6 1957	24c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn Cem	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. 3-5-57	REGISTRAR'S SIGNATURE W. R. Peterson	25. FUNERAL DIRECTOR'S SIGNATURE ADKINS FUNERAL HOME	ADDRESS Kans City, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
W. R. Peterson

notched

initials

notched

who death

who death

initials

General Hospital No

March 2, 1924

reason

age

sex

height

weight

hair

Bellevue Hospital, New York

initials

initials

STATEMENT BY LICENSED EMBALMER

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 _____

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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