

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED VS JUL 21 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-024016

STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 66

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairfax mo</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rock-Port mo</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fairfax Hospital</u>			Length of stay in 1b		d. STREET ADDRESS <u>P.O. 3</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nela</u> Middle _____ Last <u>Nelson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1959</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>aug-5-1868</u>		9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u>	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>2</u>	
13a. FATHER'S NAME <u>Nela Monsen Nelson</u>			13b. MOTHER'S MAIDEN NAME <u>Hannah Matheson</u>			14. NAME OF HUSBAND OR WIFE <u>Mary Catherine Nelson (deceased)</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>491-42-3412</u>		17. INFORMANT <u>See Nelson Westboro mo</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 years</u>		
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 <u>July 1952</u> to <u>July 8-59</u> and last saw ^{her} _(him) alive on <u>2:45 7-8-59</u> Death occurred at <u>3:30 10m</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Wallace Carpenter m.p.</u> (Degree or title)			22b. ADDRESS <u>Rock Port mo</u>			22c. DATE SIGNED <u>7-10-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>July 11 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's cemetery</u>		23d. LOCATION (City, town, or county) <u>Westboro</u>		(State) <u>mo</u>	
24. FUNERAL DIRECTOR <u>Bestman Funeral Home - Rock Port</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>July 14, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Harwin A. Wheeler</u>		

Discarded Emballer'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 *E. E. Johnson*

Licensed Embalmer No. *1264*

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