

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007426

FILED VS MAR 7 1960

Registration District No. 231 Primary Registration District No. 3048 Registrar's No. 49

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Nodaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maryville</u>		Length of stay in 1b <u>1 month</u>	c. CITY OR TOWN <u>Guilford</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Francis Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Jane</u> Last <u>Nelson</u>			4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1960</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>cau.</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>11-29-1868</u>	9. AGE (last birthday) <u>91</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home-own</u>	11. BIRTHPLACE (City and state or country) <u>Chariton, Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William Shore</u>		13b. MOTHER'S MAIDEN NAME <u>Mercy Jane Robinson</u>		14. NAME OF HUSBAND OR WIFE <u>Jacob Nelson</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>none</u>		17. INFORMANT <u>Council Bluffs, Ia. Mrs. Jennie May Larsen</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 hemorrhage & Rt. hemiplegia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis & hypertension</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)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 _____ a.m. _____ p.m. _____	Month, Day, Year.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>Jan 6, 1960</u> to <u>Feb 12, 1960</u> and last saw her alive on <u>Feb 11, 1960</u> Death occurred at <u>1:25 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W.R. Jackson M.D.</u> (Degree or title)		22b. ADDRESS <u>Maryville, Mo.</u>	22c. DATE SIGNED <u>2/26/60</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>2/14/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Graves Cemetery</u>	23d. LOCATION (City, town, or county) <u>Guilford Mo.</u>
24. FUNERAL DIRECTOR <u>Dr. Arthur Maryville Mo</u> ADDRESS <u>Mo 3-1 60</u>		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <u>Bess Bolt</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by George M. Atkinson Jr., Student Embalmer No. 600

working under my personal supervision.

Student George M. Atkinson Jr. Signed G. M. Atkinson
Signature of Student Embalmer

Licensed Embalmer No. 227

P. O. Address Maryland

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.