

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041386  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 584

AMENDED FILED DEC 12 1961

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY JOHNSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN INDEPENDENCE		c. CITY OR TOWN MISSION	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 15310 E. 39th St.		d. STREET ADDRESS (If outside, give location) 5900 MISSION ROAD	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD STEVENS NELSON			4. DATE OF DEATH Month Day Year DECEMBER 4, 1961
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 2-7-1890
9. AGE (last birthday) 71		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY AMERICAN CREDIT INDEMNITY SEDALIA, MISSOURI	
11. BIRTHPLACE (City and state or country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME UNKNOWN NELSON		13b. MOTHER'S MAIDEN NAME RUTH ELLEN STEVENS	
14. NAME OF HUSBAND OR WIFE ROSE MARIE NELSON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NDS W.W.I U.S. Army	
16. INFORMANT R.A. Nelson, 6300 E. 99th St., K.C., Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke &amp; Hemorrhage resulting from</i> DUE TO (b) <i>gun shot wounds of head and</i> DUE TO (c) <i>abdomen</i>			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>Was shot in head &amp; abdomen</i>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 12-4-61		20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <i>Home</i>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>Independence Jackson Mo</i>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Dr. Charles W. DeLoach, Coronary</i>		22b. ADDRESS <i>602 1/2 Market St. Over</i>	
22c. DATE SIGNED 12-5-61		22d. DATE SIGNED	
23a. BURIAL CREATION, REMOVAL (Specify) BURIAL		23b. DATE 12-7-61	
23c. NAME OF CEMETERY OR CREMATORY CLINTON CEMETERY		23d. LOCATION (City, town, or county) CLINTON, MISSOURI	
24. FUNERAL DIRECTOR GEO. C. CARSON & SONS, INDEPENDENCE, MO.		25. DATE RECD. BY LOCAL REG. 12-5-61	
26. REGISTRAR'S SIGNATURE <i>Alba L. Craig</i>			

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 4 1962

**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 Oranhall & Blackwell

Licensed Embalmer No. 4713

P. O. Address Raytown, 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.