

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044938

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6388

FILED JAN 8 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY JACKSON	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY	a. STATE MISSOURI COUNTY JACKSON	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4630 MONTGALL AVENUE		Length of stay in 1b 5 YEARS	d. STREET ADDRESS (If outside, give location) 4630 MONTGALL AVENUE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First AVA	Middle ESHBAUGH	Last NELSON	Month DECEMBER	Day 19	Year 1961
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/23/77	9. AGE (last birthday) 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	11. BIRTHPLACE (City and state or country) ICONIUM, MISSOURI	12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME WILLIAM NELSON		13b. MOTHER'S MAIDEN NAME REBECCA SMITH		14. NAME OF HUSBAND OR WIFE MYRTLE NELSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			17. INFORMANT OSCAR J. NELSON Address 4630 MONTGALL AVE. KANSAS CITY, MO.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 1 WK.
IMMEDIATE CAUSE (a)	CEREBRO-VASCULAR ACCIDENT	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ARTERIOSCLEROSIS GENERALIZED	
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
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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 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 **DEC-17 1961** to **DEC 18 1961** last saw him alive on **DEC 17 1961**
Death occurred at **12:25 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) Edward P. Altomare M.D.		22b. ADDRESS 2610 E 63rd St	22c. DATE SIGNED DEC 19 1961
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE DEC. 21, '61	23c. NAME OF CEMETERY OR CREMATORIUM SMITH BEND CEMETERY	23d. LOCATION (City, town, or county) (State) ST. CLAIR COUNTY, MISSOURI 61
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS ADDRESS 1331 BRUSH CR. KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 12-20-61	26. REGISTRAR'S SIGNATURE Ruth Long	

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF Edward P. Altomare MEDICAL CERTIFICATION

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 *Raymond M. Hardy*

Licensed Embalmer No. *4913*

P. O. Address *Index. 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.