

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

10131
Do not use this space.

1. PLACE OF DEATH

(a) County BUCHANAN Registration District No. 85
 (b) Township WASHINGTON Primary Registration District No. 1001 Registered No. 289
 (c) City ST. JOSEPH, (d) Street No. 1824 NORTH 2ND ST. St.
 (e) Length of residence in city or town where death occurred 35 (If death occurred in Hospital or Institution, write its name instead of street and number)
 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

NELSON, MRS. IRENE ANNA
 (a) Residence, No. 1824 NORTH 2ND ST. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF CARL ROBERT NELSON

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JUNE 5, 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
64 9 14

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWIFE
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) HARRISON COUNTY IOWA.

FATHER 13. NAME BARTON STONE PARKER

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ILLINOIS

MOTHER 15. MAIDEN NAME ELIZA JANE SELLERS

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ILLINOIS

17. INFORMANT (ADDRESS) CARL R. NELSON,
1824 NORTH 2ND ST. ST. JOSEPH

18. BURIAL, CREMATION, OR REMOVAL PLACE MEMORIAL PK. CEM. DATE MARCH 21, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) FLEEMAN & SON INC.
1946 COLHOUN ST. ST. JOSEPH, MO.

20. FILED Mar. 20, 1939 H. J. Neelbush
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MARCH 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from 3-17, 1939, to 3-19, 1939

I last saw h. ER alive on 3-19, 1939 Death is said to have occurred on the date stated above, at 5:00 P.M.

The principal cause of death and related causes of importance were as follows:

Consecutive Heart Failure Date of onset 3-10-39

Other contributory causes of importance: Hypertension 1936

Name of operation none Date of none
 What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury, 19.....

Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify

(Signed) Iwina J. Rosenthal, M. D.
 (Address) Central Bldg
St. Joseph, Mo.

John

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed John E. Ruff

Licensed Embalmer No. 3986

P. O. Address St. Joseph

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

10.131
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
 (b) Township St Joseph Primary Registration District No. 10 01 Registered No. 289
 (c) City St Joseph (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Mrs Irene Anna Nelson
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3 - 19 1937

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 9 14

Coronary Heart disease
failure
Chronic myocarditis
Hypertension

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

Date of onset _____
 Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19____ Local Registrar

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify Dr. I Rosenthal, M. D.
 (Signed) _____ (Address) St Joseph Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENT

MAY - 3 1930