

1939 APR 15

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

10675
Do not use this space.

1. PLACE OF DEATH

(a) County Deer Registration District No. 266

(b) Township Springcreek Primary Registration District No. 3310

(c) City _____ (d) Street No. _____

(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) St. _____

(f) How long in U. S., if of foreign birth? yrs. mos. ds. _____

2. PRINT FULL NAME Albert C. Nelson

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

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 Tilda Nelson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 2 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 69 1

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

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) Sweden

13. NAME Clas W. Nelson

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

15. MAIDEN NAME Ora C. Nelson

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

17. INFORMANT (ADDRESS) Tilda Nelson
Salem Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Dry Fork Cemetery DATE 3-26-1939

19. FUNERAL DIRECTOR (ADDRESS) W. J. J. J. J.
Salem Missouri

20. FILED March 26, 1939 A. E. Keith MD
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 25, 1939

22. I HEREBY CERTIFY, That I attended deceased from 12/29 1938 to 2/11/1939

I last saw him alive on 2/17/1939 Death is said to have occurred on the date stated above, at 3:00 a. m.

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

Date of onset 1939

Other contributory causes of importance:
Influenza

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 _____ (Signed) Phog H. Hunt, M. D.
(Address) Salem, Mo

UNFADING INK---THIS IS A MANDATORY RECORD
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.

11/18

STATEMENT BY LICENSED EMBALMER

I, N D Johnson, Licensed Embalmer No. 928

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No.....or by....., Registered Apprentice No.....
working under my personal supervision.

Signed N D Johnson

Licensed Embalmer No. 928

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

10675-
Do not use this space.

1. PLACE OF DEATH
 (a) County Dent Registration District No. 266
 (b) Township Spring Creek Primary Registration District No. 3370 Registered No.
 (c) City (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Albert C. 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 m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE YEARS 69 MONTHS 1 DAYS 23 If LESS than 1 day, hrs. or min.

OCCUPATION
 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

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

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

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-20-1937

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:
Latent abscess
cause unknown
 Date of onset
 Other contributory causes of importance:
Influenza
arthritis

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
 (Signed) Lloyd H. Hunt, M. D.
 (Address) Salem, Mo.

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Local Registrar.

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