REC'D APR 20 1939

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

10866
Do not use this space.

1. PLACE OF DEATH
(a) County GREENE
(b) Township Campbell
or
(c) City SPRINGFIELD
Registration District No. 318
Primary Registration District No. 2001
Registered No. 287
(d) Street No. 545 W Madison 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.

39
425
6

2. PRINT FULL NAME MARTIN DONALD NELSON
(a) Residence, No. 545 W Madison 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 M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Hazel Ousley Hazel Ousley Nelson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 23-1890
7. AGE YEARS 48 MONTHS 5 DAYS ~~10~~ 21 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Lab
9. Industry or business in which work was done, as saw mill, bank, etc. Dealer
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) Conway Mo

FATHER
13. NAME Pete Nelson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Conway Mo

MOTHER
15. MAIDEN NAME Mary Ann Oconer
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jefferson City Mo

17. INFORMANT (ADDRESS) Mrs Hazel Nelson 545 W Madison

18. BURIAL ~~CREMATION, OR REMOVAL~~ PLACE National Cem DATE 4-5 1939

19. FUNERAL DIRECTOR (NAME) Dugan-Hall (ADDRESS) Springfield Mo

20. FILED Apr 5 1939 Chas A George M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 4 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
I last saw him ~~in~~ alive on Apr 4, 1939. Death is said to have occurred on the date stated above, at 1.230 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Occlusion	
4 hr	

Other contributory causes of importance:
Arteritis

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

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) J. Ferguson Carroll M.D.
(Address) 1040 Sellm Springfield

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT 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.

50M-8-1 X16805

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 Floyd W. Fox

Licensed Embalmer No. 2910

P. O. Address 629 W Walnut

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.