

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24724**
Registrar's No. **783**

Registration District No. **85**
Primary Registration District No. **5127**

1. PLACE OF DEATH:

(a) County **Buchanan Washington**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R. R. #1 St. Joseph, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **12 years** (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph, Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **R. R. #1 1/2 Mile East St. Joseph,**
(If rural, give location) **Mo.**
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **19**
year **1940** hour **12:50** minute _____ P. M.
21. I hereby certify that I attended the deceased from **Aug 30**
1938 to **July 19**, 1940
that I last saw him alive on **July 18**, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic myocardial insufficiency
Duration
unknown
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **Joel Nilson 125**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Dollie Ann Nilson**
6. (c) Age of husband or wife if alive **41** years
7. Birth date of deceased **July 21 1888**
(Month) (Day) (Year)

8. AGE: Years **51** Months **11** Days **28**
If less than one day _____ hr. _____ min.

9. Birthplace **Riley County, Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Gustaf Nilson**
13. Birthplace **Unknown Sweden**
(City, town, or county) (State or foreign country)
14. Maiden name **Hannah Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dollie A. Nilson**
(b) Address **R. R. #1 St. Joseph, Missouri**

17. (a) **Burial** (b) Date thereof **7-22-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
St. Joseph, Mo. Memorial Park Cemetery
(c) Place: burial or cremation

18. (a) Signature of funeral director **Walter Meierhofer**
(b) Address **1302, Faraon St. St. Joseph, Mo.**

19. (a) **7/23/40** (b) **H. J. Rittenbach**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
85 (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature **Gustaf Nilson** (M. D. or other) **MD**
Address **St. Joseph Mo** Date signed **7-19-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 19 1949

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.....

W. H. Kelly

Licensed Embalmer No. Mo. #3946.....

P. O. Address: St. Joseph, 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 this body is not embalmed, above space should be left blank.