

FILLED JUL 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22151

State File No. _____

on District No. 547

Primary Registration District No. 3029

Registrar's No. 171

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Levering Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

(c) City or town Hannibal
(If outside city or town limits, write "RURAL")

(d) Street No. 616 South Main St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME James A Nelson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month May day 27
year 1941 hour 530 A. M. minute _____ M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lucey 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 28 1883
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 3-22-41 to 3--27--19
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
81 11 28 hr. _____ min.

Immediate cause of death Congestive Heart failure
Pneumonia
Parotitis

Due to _____

Due to _____

9. Birthplace Keokuk Iowa
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation Retired Railroad Man

11. Industry or business _____

12. Name Muriel Nelson

13. Birthplace Iowa
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace Iowa
(City, town, or county) (State or foreign country)

Major findings: Of operations none

Of autopsy none

16. (a) Informant Lucey Nelson

(b) Address 616 South Main St.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof 5 29 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olivet Cemetery

(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? _____

18. (a) Signature of funeral director [Signature]

(b) Address Hannibal Mo.

19. (a) June 2, 1941 (b) W. C. Fisher
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) _____

Address Hannibal Mo. Date signed 5-27-41

(Licensed Embalmer's Statement on Reverse Side)

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

200A

64
5
4
0

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

9372

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.....
Samuel O'Connell

Licensed Embalmer No. 3889

P. O. Address.....
Sumner St. 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, fact should be so stated above.

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Registration District No. 547

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1. PLACE OF DEATH:

(a) County Marion
(b) City or town Fanshibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME James A Nelson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

{ 14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Marion
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH: Month May day 27
year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Duration
Immediate cause of death: Congestive heart failure
Due to: Pneumonia lobar
Due to: Parotitis Mumps
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: See Handwritten
Of operations _____
Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
44C

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? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTAL

