. No. 2
—1-4-41
5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 16 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23965

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2504

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: General Hospital #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6-1-41-6-2-41 (Specify whether

In this community 8 hours. years, months or days) 0

2. USUAL RESIDENCE OF DECEASED: 048

(a) State Mo. (b) County Jackson 3

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 8

(d) Street No. General Hospital #2 728½ Campbell (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Infant Nelson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 6 (Month) 1 (Day) 1941 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 8 hr. min.

9. Birthplace Kansas City (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation None

11. Industry or business

FATHER
12. Name James Nelson
13. Birthplace Richmond (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Katie Saunders
15. Birthplace Richmond (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-41 (Month) (Day) (Year)

(c) Place: burial or cremation Leeds

18. (a) Signature of funeral director Wm A Lohmeyer

(b) Address City Mortician

19. (a) 7-2-41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 2 year 41 hour 7 minute 50 A. M.

21. I hereby certify that I attended the deceased from 6-1- 1941 to 6-2- 1941 that I last saw him alive on 6-2- 1941 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Premature	
Due to 159	
Due to	
Other conditions (Include pregnancy within 3 months of death) 159	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. C. Turner (M. D. or other) D

Address Gen. Hosp. #2 Date signed 6-2-41

561 (Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.