

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

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:
840 West 39th
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **50 years**
years, months or days)

3. (a) PRINT FULL NAME **MRS. CHRISTINE LOUISE NELSON**

3. (b) If veteran, name war **NO**
3. (c) Social Security No. **NONE**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **2**

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

7. Birth date of deceased **October 9th 1863**
(Month) (Day) (Year)

8. AGE: Years **80** Months **6** Days **0**
If less than one day _____ hr. _____ min.

9. Birthplace **Sweden 4**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home**

11. Industry or business _____

12. Name **Unknown**

13. Birthplace **Sweden 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Sweden 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Gertrude Nelson**

(b) Address **840 West 39th Terrace**

17. (a) **Burial** (b) Date thereof **4-12-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Moriah Cemetery**

18. (a) Signature of funeral director **Freeman Mortuary**
(b) Address **104 west 42nd street**

19. (a) **4-10-44** (b) **D. E. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **48**
(a) State **Missouri** (b) County **Jackson 3**
(c) City or town **Kansas City 8**
(If outside city or town limits, write "RURAL")
(d) Street No. **840 West 39th Terrace**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **9th**
year **1944** hour **1** minute **55 P.M.**

21. I hereby certify that I attended the deceased from **4-3-44** to **4-9-44**
that I last saw **her** alive on **4-9-44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Failure**
Toxemia

Due to **Apoplexy** **5 yrs.**

Due to **Arteriosclerosis** **10 yrs.**

Other conditions **Senility**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **(3)**
Of autopsy _____

Duration **2 wks.**
2 mo.
5 yrs.
10 yrs.
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 **D. E. Brown** (M. D. or other) **DO**
Address **3105 T. 0025** Date signed **4-10-44**

Mr. Pease
31st Street

after 2 P.M.

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 Walter H. Cowin
Licensed Embalmer No. 4352
P. O. Address Kansas City 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.