

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10037
Registrar's No. 1495

Dr. Broyles
FILED APR 15 1944
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

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

(d) Length of stay: In hospital or institution 1 Day
In this community 1 Year
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ralph NESBETT

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July 16th, 1938
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>5</u>	<u>8</u>	<u>17</u>	hr. min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER {

12. Name Robert L. Nesbett

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

14. Maiden name Lebna Ruth Chatham

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

16. (a) Informant Robert L. Nesbett

(b) Address Pittsburg Kansas.

17. (a) Removal. (b) Date thereof 4-5-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osborne Kans

18. (a) Signature of funeral director Melody-McGilley

(b) Address K. C. Mo.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 3305 East 31 St.
(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 3rd
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from April 3
1944 to April 3 1944
that I last saw him alive on April 3 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure
Edema of trachea

Due to	Duration
<u>Laryngotracheobronchitis</u>	<u>12 hours</u>
<u>Tracheitis & pharyngitis</u>	<u>4 days</u>

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

Major findings:
Of operations _____

X 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) _____

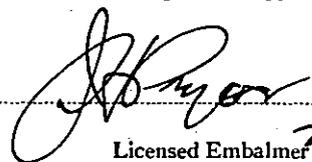
While at work? _____ (e) Means of injury _____

23. Signature W. E. Brown (M. D. or other) W. E.
Address 1132 Prof. Bldg Date signed 4-4-44

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. 2999

P. O. Address..... KC

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.