S. No. 2
DM—2-43
V. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27647

Registration District No. 181 Primary Registration District No. 2001 Registrar's No.

1. PLACE OF DEATH:
(a) County: Jasper
(b) City or town: Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 days (Specify whether years, months or days)
In this community: 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jasper
(c) City or town: Carthage
(If outside city or town limits, write "RURAL")
(d) Street No.: 605 Center
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: - - -

3. (a) PRINT FULL NAME: David Woodrow Nelson
3. (b) If veteran, name war: No
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: August (Month) 8 (Day) 1945 (Year)
8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.
9. Birthplace: Joplin (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Infant
11. Industry or business: None
12. FATHER Name: J. D. Nelson
13. FATHER Birthplace: McAllister (City, town, or county) Okla (State or foreign country)
14. MOTHER Maiden name: Leota Sweaney
15. MOTHER Birthplace: Bolivar (City, town, or county) Mo. (State or foreign country)
16. (a) Informant: J. D. Nelson
(b) Address: 605 Center, Carthage, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 11, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Fullerton Cemetery
18. (a) Signature of funeral director: Knell Mortuary
(b) Address: Carthage, Missouri
19. (a) 8-10-45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 9 year 1945 hour 3 minute 10 p. M.
21. I hereby certify that I attended the deceased from 8/9/45, 19..., to 8-9-45, 19...; that I last saw him alive on 8-9-45, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemorrhagic Disease of New Born	Instt
Due to:	
Due to: Atelectasis of Rt Lung	Instt
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.

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: [signature] (M. D. or other)
Address: Date signed 8/13/45

1404 (Licensed Embalmer's Statement on Reverse Side)

45-8-699

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed by me, or by .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Lucy Knee-Buckwell

Licensed Embalmer No. 2510

P. O. Address Carthage, 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.