S. No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 18 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9599

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1173

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 No. 1 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos. (Specify whether
In this community not known
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 4

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 611 W-11 St 8
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Nels Oakson

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race W

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 Not known
(Month) (Day) (Year)

8. AGE: Years about 70 | Months | Days | If less than one day hr. min.

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

10. Usual occupation 9

11. Industry or business

FATHER
12. Name Not known 9
13. Birthplace 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name 9
15. Birthplace 1
(City, town, or county) (State or foreign country)

16. (a) Informant Record Office
(b) Address K.C.G. Hospital

17. (a) K.C. Mort Co. (b) Date thereof 3-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lee

18. (a) Signature of funeral director Wm A Lohmeyer
(b) Address K C Gen Hospt

19. (a) 3-9-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 19
year 1946 hour 5 minute 15 P.M.

21. I hereby certify that I attended the deceased from Dec. 20, 1945, to Feb. 19, 1946; that I last saw him alive on Feb. 19, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary occlusion	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 94a	

Major findings:
Of operations
Of autopsy None

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 0

23. Signature Clark W Seeley M.D.
Address Med. Dir. Gen'l Hosp. Date signed 2-20-46

(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 .....

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

working under my personal supervision.

Signed Wm A Robinson

Licensed Embalmer No. 3089

P. O. Address KC 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.