S. No. 2
—12-45
. 5-17-39
I X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12543

FILED APR 28 1947

Registration District No. 4

Primary Registration District No. 1000

Registrar's No. 546

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 12 Hours.
In this community: Entire lifetime.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri. (b) County: Buchanan.
(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No.: 916 South 16th. Street,
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Garry Dale 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, married, widowed, or divorced: Infant, single
6. (b) Name of husband or wife: ------
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: April (Month) 13th. (Day) 1947 (Year)

8. AGE: Years | Months | Days | If less than one day
--- | --- | 5 | hr. min.

9. Birthplace: St. Joseph, Missouri. (City, town, or county) (State or foreign country)
10. Usual occupation: Infant.
11. Industry or business: ------
FATHER
12. Name: Charles Clifton Nelson.
13. Birthplace: Truo, Iowa. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Betty Jane Fisher.
15. Birthplace: St. Joseph, Missouri. (City, town, or county) (State or foreign country)
16. (a) Informant: Charles Clifton Nelson.
(b) Address: 916 South 16th. Street,
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr.21,1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Auburn Cemetery
18. (a) Signature of funeral director: Sisson Funeral Home
(b) Address: 602 South 10th. Street,
19. (a) 4-21-47 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18th. year 1947 hour minute 30 A.M.

21. I hereby certify that I attended the deceased from April 13 1947 to April 18 1947 that I last saw him alive on April 17 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia, Paramon Duration: 4 days.
Due to: Anal
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: L/7 P
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: Leroy Beck (M. D. or other)
Address: Kingstown Mo. Date signed: 4/18/47

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(Licensed Embalmer's Statement on Reverse Side) St. Joseph, Mo.

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 Mollie E. Sidenfaden Fox

Licensed Embalmer No. 423

P. O. Address St. Joseph, 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.