

S. No. 2  
M-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED APR 21 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

*D. Allen*  
State File No. **13760**  
Registrar's No. **104**

Registration District No. **146**

Primary Registration District No. **3026**

1. PLACE OF DEATH:  
(a) County **Jackson**  
(b) City or town **Jackson**  
(c) Name of hospital or institution **Sanitarium & Hospital**  
(d) Length of stay: In hospital or institution **71 day**  
In this community **35 yrs**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(d) Street No. **504 Newton**  
(e) Citizen of foreign country? **no**

3. (a) PRINT FULL NAME **Olof Nelson**  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. **486-03-4863**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **April** day **6** 1947  
year \_\_\_\_\_ hour \_\_\_\_\_ minute **7:15** M.

4. Sex **M** 5. Color or race **W**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Ruben**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Nov 22 - 1882**

21. I hereby certify that I attended the deceased from **April 5, 1947** to **April 6, 1947**  
that I last saw him alive on **April 6, 1947**  
and that death occurred on the date and hour stated above.

8. AGE: Years **64** Months **4** Days **15**  
If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

Immediate cause of death **Cerebral Hemorrhage**  
Due to **Hypertension**  
Duration **18 hrs**

9. Birthplace **Sweden**

Other conditions **g3**  
(Include pregnancy within 3 months of death)

10. Usual occupation **Cable splicing**

MOTHER FATHER  
11. Industry or business **Sheffield Steel Co. & em**  
12. Name **Olof Nelson**  
13. Birthplace **Sweden**  
14. Maiden name **Unknown**  
15. Birthplace **Sweden**

Major findings:  
Of operations **no operations**  
Of autopsy **no autopsy**  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant **Gladys Smith**  
(b) Address **Oak Grove mo**  
17. (a) **Burial** (b) Date thereof **4-9-47**  
(c) Place: burial or cremation **Oak Grove Mo**

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director **W. G. Sweetson**  
(b) Address **Oak Grove mo**  
19. (a) **4-8-47** (b) **Allen**  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature **D. Allen M.D.**  
Address **Independence** Date signed **4/18/47**

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

**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.....

..... *Francis J. Schuyler* ....., Registered Apprentice No. *464*  
working under my personal supervision.

Signed..... *R. B. Webb* .....

Licensed Embalmer No. *2303*

P. O. Address..... *Blue Springs 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.**