

S. No. 2
DM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17550**
2005
Registrar's No.

FILED MAY 20 1947
149

Registration District No. _____ 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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3910 Woodland
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether
In this community 36 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 3910 Woodland Avenue 8
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Muriel M. NELSON
(b) -If veteran, name war no
(c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 5
year 1947 hour 5 minute 30 A.M.

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Jacob Nelson
6. (c) Age of husband or wife, alive _____ years
7. Birth date of deceased November 18, 1888
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
4-7-47, 19____, to 5-5-47, 19____;
that I last saw her alive on 5-5-47, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years 58 Months 5 Days 17
If less than one day hr. _____ min. _____

Immediate cause of death
Heart failure + acute infection
Due to _____
Due to _____

9. Birthplace: Gladstone, Illinois
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
9 5 10

10. Usual occupation: Housewife
11. Industry or business: At home

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name William Snyder 9
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Cora E. Welch
15. Birthplace Unknown Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant: Clinton A. Nelson
(b) Address 3506 Montgall, K. C., Mo.
17. (a) Burial (b) Date thereof 5-7-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cemetery

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?
While at work? _____ (Specify type of place) (e) Means of injury 0

18. (a) Signature of funeral director: Melody-McGilley-Eylar
(b) Address Kansas City, Missouri
19. (a) 5-5-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

23. Signature: Rev. G. Beardsley (M. D. or other) _____
Address 3447 Prospect Date signed 5-5-47

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 *Elen E Heck*.....

Licensed Embalmer No. *4063*.....

P. O. Address *Kansas City, 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.