

FILED APR 24 1948 / 149

Primary Registration District No. 1002

Registrar's No. 1688

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:  
4 Conv. Home 572 Woodland  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution about 9 months  
 (Specify whether  
 In this community 43 yr  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 512 Woodland  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. EOLINE NELSON

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex 71 5. Color or race W 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Chas B Nelson 6. (c) Age of husband or wife if alive 74 years  
 7. Birth date of deceased 7-18-1875  
 (Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 28 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Refugio County Tex  
 (City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business \_\_\_\_\_

12. Name Delmas DuBois  
 13. Birthplace Ta  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Frances Kibbee  
 15. Birthplace Ta  
 (City, town, or county) (State or foreign country)

16. (a) Informant Robert Nelson

(b) Address Kansas City Mo

17. (a) Burial (b) Date thereof 4-19-48  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cem

18. (a) Signature of funeral director W B Langford

(b) Address 1135 DuSable

19. (a) 4-18-48 (b) Shiraldine Jones  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16,  
 year 1948 - hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Jan 1 1945 to April 16 1948  
 that I last saw him alive on April 16 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Arteriosclerosis  
Chr. Myocarditis

Due to arteriosclerosis

Due to Hypertension

Other conditions no  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations no  
 Of autopsy no

Duration  
5 yrs  
5 yrs  
 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?  
 \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W B Langford (M. D. or other)  
4000 Baltimore Date signed 4/17/48

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

48  
 3  
 8

8  
 0

72-9110

*Dr. Carl G. Ball*  
*4000 B. & O. Dr. N.W.*

**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.....  
.....  
Licensed Embalmer No.....  
P. O. Address.....

**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.**