

FILED NOV 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 39111

9936

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) <b>Mo. St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		d. STREET ADDRESS (If rural, give location) <b>91 - 1906 O'Fallon St.</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>91 - 1906 O'Fallon St.</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Abe</b>		b. (Middle) _____		c. (Last) <b>Nelson</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>III 12 49</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>12-17-1904</b>			
9. AGE (In years last birthday) <b>44</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Port Gibson, Miss.</b>			
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <b>Henry Nelson</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Melissa Wells</b>		ADDRESS <b>1906 O'Fallon</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Malignant Hypertension</b>				ANTECEDENT CAUSES				DUE TO (b) <b>Undetermined</b>	
DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS				DUE TO (c) <b>Uremia</b>	
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) <b>102</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>HHS</b>		22. I hereby certify that I attended the deceased from <b>11-10</b> , 19 <b>49</b> , to <b>11-12</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>11-12</b> , 19 <b>49</b> , and that death occurred at <b>1:55 p. m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>J. Sedwick</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>2601 N Whittier St</b>		23c. DATE SIGNED <b>11-14-49</b>		24. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
24b. DATE <b>III-19-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W. Robinson &amp; Sons</b> ADDRESS <b>1720 O'FAL LON</b>			
DATE REC'D BY LOCAL REG. <b>NOV 18 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Barter</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W. Robinson &amp; Sons</b> ADDRESS <b>1720 O'FAL LON</b>					

(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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Leroy W. Bannister*

Licensed Embalmer No. 4523

P. O. Address 3880 Easton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.