

FILED DEC 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40636**
Registrar's No. **4-4**

BIRTH NO. _____ REG. DIST. NO. **84** PRIMARY REG. DIST. NO. **5320**

WRITE PLAINLY USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY COOPER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY COOPER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN (RURAL) PALESTINE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN (RURAL) PALESTINE	
c. LENGTH OF STAY (in this place) 35 yrs			
d. FULL NAME OF HOSPITAL OR INSTITUTION HOME		d. STREET ADDRESS (If rural, give location) HOME (PALESTINE TOWNSHIP)	

3. NAME OF DECEASED (Type or Print)	a. (First) LAURA	b. (Middle) HESTER	c. (Last) NELSON	4. DATE OF DEATH	Month Dec (Day) 6 (Year) 1949
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5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DEC. 1 - 1897	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 14 HRS. Hours	IF UNDER 14 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) COOPER COUNTY - MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME CHARLES SHIRLEY	13b. MOTHER'S MAIDEN NAME LOUISE WILLIAMS	14. NAME OF HUSBAND OR WIFE WILLIAM NELSON
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME WILLIAM NELSON - SPEED - MO.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Large Bowel	DUE TO (b) _____		153X
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.	_____		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Nov 25, 1949**, to **Dec 6, 1949**, that I last saw the deceased alive on **Nov 25, 1949**, and that death occurred at **2 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. L. DeKraeyn M.D.	23b. ADDRESS Boonville Mo	23c. DATE SIGNED 12/8/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12/9/49	24c. NAME OF CEMETERY OR CREMATORY BUNCETON CEMETERY	24d. LOCATION (City, town, or county) (State) BUNCETON - MO.
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DATE REC'D BY LOCAL REG. Dec 9 - 49	REGISTRAR'S SIGNATURE Kellie Thellett	25. FUNERAL DIRECTOR'S SIGNATURE STEGNER FUNERAL HOME-BOONVILLE MO	ADDRESS
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RECEIVED DEC 14

District Health Officer No. 8,

District File Number _____

Date Filed 12-21-49

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 James W. Segner

Licensed Embalmer No. ~~3780~~ 3780

P. O. Address BOONVILLE - 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.