

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

5173

FILED FEB 16 1952

612

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1001</u>		Registrar's No. <u>612</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>49 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u>				d. STREET ADDRESS (If rural, give location) <u>3220 St. John</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u>		b. (Middle) <u>WILLARD</u>		c. (Last) <u>Nelson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 7 52</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>AUGUST 10, 1863</u>	
9. AGE (In years last birthday) <u>88</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPTOMETRIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13a. FATHER'S NAME <u>JOSEPH NELSON</u>		13b. MOTHER'S MAIDEN NAME <u>SALLIE LEMON</u>		14. NAME OF HUSBAND OR WIFE <u>LILLIAN NELSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>LILLIAN NELSON - 3220 St. John</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic heart disease with left ventricular failure</u> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH <u>4200</u>
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 28</u> , 19 <u>52</u> to <u>Feb. 7</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>Feb. 7</u> , 19 <u>52</u> , and that death occurred at <u>12:50 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>H. Stratemeier MD</u> (Degree or title)				23b. ADDRESS <u>24th & Cherry</u>		23c. DATE SIGNED <u>2-8-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>FEB 9, 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>PACKARD CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>CAMERON Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2-8-52</u>		REGISTRAR'S SIGNATURE <u>Verdelline Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C.H. Blackman & Son Inc. K.C., Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Harrison

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 *W.C. Primm*

Licensed Embalmer No. *4879*

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.