

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3121

BIRTH NO. FILED FEB 4 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0848

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 4338 St Ferdinand 2119	

3. NAME OF DECEASED (Type or Print) MATTIE	a. (First)	b. (Middle) M	c. (Last) NELSON	4. DATE OF DEATH Jan 23 1954
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5. SEX Female	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov 25 1900	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 28	IF UNDER 1 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and State or Foreign Country) Paris Texas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Daniel Young	13b. MOTHER'S MAIDEN NAME Mollie Fullbright	14. NAME OF HUSBAND OR WIFE Hugh M. Nelson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Hugh M. Nelson	ADDRESS 4338 St Ferdinand
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES DUE TO (b) Cerebral Apoplexy Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 checked="" 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? 334X
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Name or title) <i>Wm E Joyce</i>	23b. ADDRESS 1300 Clark Avenue	23c. DATE SIGNED 1/21/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Jan. 28, 1954	24c. NAME OF CEMETERY OR CREMATORY Paris	24d. LOCATION (City, town, or county) (State) Texas
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DATE REC'D BY LOCAL REG. JAN 27 1954	REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE J.H. Randle & Son	ADDRESS 3133 Bell Ave
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed..... *S. J. Watson*

Licensed Embalmer No. *2169*

P. O. Address *2719th*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting,
If this body is not embalmed, fact should be so stated above.