

FILED JUL 12 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19299

State File No.

 BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 111

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural prairie</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Prairie</u> <u>1000</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jackson County Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>R 4 Independence, Mo</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>May</u>	b. (Middle)	c. (Last) <u>Nelson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>6-25-54</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, 9 WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1-1-1884</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Mt. Grove, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>unknown</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>unknown</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Noop. Record Dept.</u>	ADDRESS <u>Indep.</u>
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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, asphyxia, 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) <u>Cerebral vascular accident</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) <u>pernicious anemia</u> DUE TO (c) <u>chronic ulcerative colitis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>no</u>	19b. MAJOR FINDINGS OF OPERATION <u>5722</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>no</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>no</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>no</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <u>no</u>

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 _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. E. Keith</u>	(Degree or title) <u>MD</u>	23b. ADDRESS <u>204 Angyle</u>	23c. DATE SIGNED <u>6-25-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	24b. DATE <u>6-27-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield Mo</u>
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DATE REC'D BY LOCAL REG. <u>6-26-1954</u>	REGISTRAR'S SIGNATURE <u>D.B. Langford</u>	483	25. FUNERAL DIRECTOR'S SIGNATURE <u>N.W. Newcomb</u>	ADDRESS <u>R. P. Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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
Student Embalmer

Signed *Albert A. Savage*

Licensed Embalmer No. *4812*

P. O. Address *11 E. 2nd*

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.