

FILED MAY 9 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 13725
3406
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY <u>S</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, MO</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Berkley, MO</u>	
c. LENGTH OF STAY (in this place) <u>1 day</u>		d. STREET ADDRESS (If rural, give location) <u>612 2 Washington</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>De Paul Hosp</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>KENT</u> b. (Middle) <u>B</u> c. (Last) <u>NELSON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>4-15-1955</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	
8. DATE OF BIRTH <u>2/3/53</u>		9. AGE (In years last birthday) <u>1</u> if UNDER 1 YEAR: Months <u>9</u> Days <u>12</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	

13a. FATHER'S NAME <u>Donald E. Nelson</u>		13b. MOTHER'S MAIDEN NAME <u>Helen Palmer</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Donald E. Nelson</u> ADDRESS _____	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>MENINGOCOCCUS MENINGITIS</u>				
		ANTECEDENT CAUSES				
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				
		II. OTHER SIGNIFICANT CONDITIONS				
		Conditions contributing to the death but not related to the disease or condition causing death. <u>ACUTE ADRENAL INSUFFICIENCY</u>				

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <u>NCY.</u>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>057.0</u>		

22. I hereby certify that I attended the deceased from 4-15, 1955, to 4-15, 1955, that I last saw the deceased alive on 4-15-1955, and that death occurred at 3:50 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Nicholas C. Kawakas MD</u>		23b. ADDRESS <u>937 A12 Port Rd Ferguson, Mo</u>		23c. DATE SIGNED <u>4-16-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>4/17/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>tower Heights cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>West Frankfort, Ill.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Fred Beady</u>		ADDRESS <u>West Frankfort, Ill.</u>	
DATE REC'D BY LOCAL REG. <u>APR 18 1955</u>		REGISTRAR'S SIGNATURE <u>J. Carlo Smith</u>			

(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

Licensed Embalmer No. *Ill. 709*

P. O. Address.....

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

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