

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16624

State File No. \_\_\_\_\_ Registrar's No. 47

FILED MAY 31 1957

|  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>1000</u>   |   | PRIMARY REG. DIST. NO. <u>3078</u>   |  | Registrar's No. <u>47</u>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>DENT</u>   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission).<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>DENT</u> |  |  |  |
| b. CITY OR TOWN <u>SALEM</u>   |  | c. LENGTH OF STAY (in this place) <u>12 YEARS</u>  |   | c. CITY OR TOWN <u>SALEM</u> <u>033/0</u>  |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION: <u>OAK STREET</u>   |  |  |   | e. STREET ADDRESS (If rural, give location)<br><u>OAK STREET</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>LONNIE</u>  |  | b. (Middle) <u>B.</u>  |   | c. (Last) <u>NELSON</u>  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>MAY 26 1957</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>JAN. 12, 1892</u>  |  |
| 9. AGE (In years last birthday) <u>65</u>  |  | IF UNDER 1 YEAR Months _____ Days _____  |   | IF UNDER 24 HRS. Hours _____ Min. _____  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>COUNTY REPRESENTATIVE</u>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>STATE LEGISLATURE</u> |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>HOWES MILL, MISSOURI</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |
| 13a. FATHER'S NAME<br><u>JOSEPH NELSON</u>   |  |  | 13b. MOTHER'S MAIDEN NAME<br><u>CORNELIA JENKINS</u>          |  |  | 14. NAME OF HUSBAND OR WIFE<br><u>VIRGIE SHAW NELSON</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><u>486-18-9413</u>   |   | 17. INFORMANT'S SIGNATURE OR NAME<br><u>VIRGIE NELSON</u>  |  | ADDRESS<br><u>SALEM, MO.</u>   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Cardiovascular renal disease</u><br>(a) _____<br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 yrs</u>   |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION<br><br><u>442X</u>  |   |  |  |  | 20. AUTOPSY? <input type="checkbox"/> YES <input 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)  |  |  |  |
| 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?   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>fall 1955</u> , 19 <u>55</u> , to <u>5-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-26</u> , 19 <u>57</u> , and that death occurred at <u>11:55 P.M.</u> , from the causes and on the date stated above. |  |  |   |  |  |  |  |
| 23a. SIGNATURE (Signature or title)<br><u>Jos D Luc Jend, M.D.</u>   |  |  |   | 23b. ADDRESS<br><u>Salem, Mo.</u>  |  | 23c. DATE SIGNED<br><u>5-28-57</u>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 24b. DATE<br><u>May 29, 1957</u>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><u>CEDAR GROVE CEMETERY</u>  |  | 24d. LOCATION (City, town, or county) (State)<br><u>SALEM MISSOURI</u>   |  |
| DATE REC'D BY LOCAL REG.<br><u>5-28-57</u>   |  | REGISTRAR'S SIGNATURE<br><u>T. M. Hart M.D. / P. M.</u>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>May E. Warfel</u>   |  | ADDRESS<br><u>Salem, Mo</u>  |  |

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

5388

AUG 19 1959

**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 Max R. Craft

Licensed Embalmer No. 4170

P. O. Address Salem, Ms

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.