

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40945  
STATE FILE NUMBER

FILED DEC 3 - 1957

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 191

1. PLACE OF DEATH a. COUNTY <b>LACHEDE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LEBANON</b>		c. CITY OR TOWN <b>NIANGUA MO</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>KNOX NURSING HOME 2 MO</b>		d. STREET ADDRESS (If outside, give location) <b>5 MI NEAST</b>	

3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle Last <b>NELSON</b>			4. DATE OF DEATH Month <b>NOV</b> Day <b>20</b> Year <b>1957</b>		
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JAN 28 1885</b>	9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
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13a. FATHER'S NAME <b>MARION NELSON</b>	13b. MOTHER'S MAIDEN NAME <b>ELIZABETH REED</b>	14. NAME OF HUSBAND OR WIFE
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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) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>MRS JIM NELSON</b> Address <b>LEBANON MO</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Paralytic Stroke</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cardiac Decompensation</b>	<b>30 Min.</b>
	DUE TO (c) <b>334X</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <b>Nov. 17, 1957</b> to <b>Nov. 20, 1957</b> and last saw her alive on <b>Nov. 20, 1957</b> Death occurred at <b>Nov. 20, 1957 5:03 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>O. L. BOHRER, D. O.</b>	22b. ADDRESS <b>Lebanon, Missouri</b>	22c. DATE SIGNED <b>11-23-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>11-25-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CATHOLIC</b>	23d. LOCATION (City, town, or county) (State) <b>WEBSTER Co MO</b>
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24. FUNERAL DIRECTOR ADDRESS <b>BARBER-EDWARDS MARSHFIELD MO</b>	25. DATE RECD. BY LOCAL REG. <b>11-25-1957</b>	26. REGISTRAR'S SIGNATURE <b>Hella L. Hlay</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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Received 12-2-57

Laclede County Health Unit

File No. 191

Date Filed 12-2-57

### 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 *R. W. Baker* .....

Licensed Embalmer No. 3868

P. O. Address *W. B. Baker Co.*

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.