

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033925
STATE FILE NUMBER

FILED SEP 30 1958 Registration District No. 316 Primary Registration District No. 3061 Registrar's No. 359

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <i>St. Francis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Flat River</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Maplewood</i> 4544
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Tarkin Rest Home 6 mos</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>3711 Oxford</i>
3. NAME OF DECEASED (Type or print) First <i>Mollie</i> Middle <i>Lenora</i> Last <i>Nelson</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>19</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 30 1874</i>
9. AGE (In years last birthday) <i>74</i>		IF UNDER 1 YEAR Months <i>2</i> Days <i>19</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house work</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state, or country) <i>Washington Co. Mo</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13a. FATHER'S NAME <i>William Wilson</i>	
13b. MOTHER'S MAIDEN NAME <i>Rosa Nerwine</i>		14. NAME OF HUSBAND OR WIFE <i>Johnny Nelson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Johnny Nelson</i> Address <i>Maplewood Mo.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Senility</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>yes</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Senility</i>			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.)	
20c. TIME OF INJURY Hour <i></i> Month <i></i> Day <i></i> Year <i></i> a.m. <i></i> p.m. <i></i>			
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	
21. I attended the deceased from <i>May 1 58</i> to <i>Sept 19 58</i> and last saw her alive on <i>Sept 18 58</i> Death occurred at <i>530 P. m</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>J. W. Zupan D.O.</i>		22b. ADDRESS <i>Flat River Mo</i>	
22c. DATE SIGNED <i>9/21-58</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>9-21-58</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Caledonia Presbytem. Washington Co. Mo.</i>		23d. LOCATION (City, town, or county) (State) <i>Washington Co. Mo.</i>	
24. FUNERAL DIRECTOR <i>Mrs. Luther Spahr Peterson</i>		25. DATE RECD. BY LOCAL REG. <i>Sept. 21, 1958</i>	
ADDRESS		26. REGISTRAR'S SIGNATURE <i>Ether Gulloff</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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[Handwritten signature]

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 *[Handwritten name]*, Student Embalmer No. working under my personal supervision.

Student

Signature of Student Embalmer

Signed *Murphy L. Spahr*

Licensed Embalmer No. 4236

P. O. Address *Flat River 7*

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.

82-814901
82-814902

82-10/17

[Handwritten notes and signatures]