

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013468

STATE FILE NUMBER

FILED APR 20 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1658

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3224 Cleveland</b>		Length of stay in 1b <b>About 30 years</b>	d. STREET ADDRESS (If outside, give location) <b>3224 Cleveland</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BETTY</b> Middle <b>NELSON</b> Last <b>NELSON</b>			4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-15</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	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>Clarksville, Texas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Columbus Hensley</b>		13b. MOTHER'S MAIDEN NAME <b>Amanda Nunley</b>		14. NAME OF HUSBAND OR WIFE <b>John Nelson</b>	
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. <b>---</b>	17. INFORMANT Address <b>Mrs. Mittie Williams-1701 E. 27th. St. Lubbock, Tex.</b>		
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>Cardiac Failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 MO.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <b>Hypertension</b>					6 years
DUE TO (c) _____					
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.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <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 <b>March 15-59</b> to <b>March 30-59</b> and last saw her/him alive on <b>March 30-59</b> Death occurred at <b>3:00 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>E. F. Walls</b>			(Degree or title) <b>1</b>	22b. ADDRESS <b>2628 Taost</b>	22c. DATE SIGNED <b>4-1-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/3/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Lawn Cemetary</b>	23d. LOCATION (City, town, or county) <b>Kansas City, Mo.</b> (State)		
24. FUNERAL DIRECTOR <b>E. Steiny</b>		ADDRESS <b>Bills 1212 ring</b>	25. DATE RECD. BY LOCAL REG. <b>4-1-59</b>	26. REGISTRAR'S SIGNATURE <b>Neve Minshall</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

E. F. Walls

All diseases in Part I must be causally related.

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 ... *E. Sterling Mills* .....

Licensed Embalmer No. 3178.....  
1212 Vine St.  
P. O. Address Kansas City, Mo. ....

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.