

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001560

STATE FILE NUMBER

FILED KS. JAN 24 1961

149

Primary Registration District No. 1002 Registrar's No.

78

AMENDED

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>			Length of stay in lb <b>44 yrs.</b>		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>St. Joseph Hospital</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1824 Kensington</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Maybelle</b> Middle <b>J.</b> Last <b>Nelson</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>6.</b> Year <b>1961</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/18/1892</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office work - Montgomery Ward &amp; Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ward &amp; Co.</b>		11. BIRTHPLACE (City and state or country) <b>Wallace, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>John O. Fall</b>			13b. MOTHER'S MAIDEN NAME <b>Sophia C. Carlson</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.		17. INFORMANT Address <b>John Nelson 1824 Kensington</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b>							<b>2 Days</b>
DUE TO (b) <b>Cerebral Hemorrhage</b>							<b>10 Days</b>
DUE TO (c) <b>Hypertensive Cardio-Vascular Dis.</b>							<b>15 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I.							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 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 <b>October 1959</b> to <b>Jan. 6, 1960</b> and last saw her alive on <b>Jan. 4, 1961</b> Death occurred at <b>5:15 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Ad Eselman, M.D.</b>				22b. ADDRESS <b>9306 E New 40 Highway Independence, Mo.</b>		22c. DATE SIGNED <b>Jan 6, 1961</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Jan. 9, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah Cemetery</b>		23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>		(State)
24. FUNERAL DIRECTOR ADDRESS <b>Earp &amp; Sons Kansas City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>1-6-61</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 1-10-61  
 INSTEAD OF  
 510-35-7146B.  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF Informant  
 ITEM NO. SHOULD READ  
 16 489-30-0682

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body<sup>s</sup>, 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

*William H. Egan*

Licensed Embalmer No.

*4728*

P. O. Address

*K. P. 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.