

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048181

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6670

FILED DEC 19 1963

VS 300 Rev. 4/59	DATE AMENDED
1	
2 <u>3188</u>	
3	
4 <u>0</u>	
5 <u>1</u>	
6	
7 <u>1</u>	
8 <u>2</u>	
9 <u>157X</u>	
10	
11	
12 <u>6100</u>	
13	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN KANSAS CITY		Length of stay in 1b 10 YRS.	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARY'S HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2631 E. 10th. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JAMES BUCHANAN NELSON			4. DATE OF DEATH Month Day Year DECEMBER 7, 1963
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-6-1931
9. AGE (last birthday) 32		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PATTERN MAKER		10b. KIND OF BUSINESS OR INDUSTRY ADVANCE PATTERN CO.	11. BIRTHPLACE (City and state or country) SELMA, ALABAMA
12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME HUTSON NELSON		13b. MOTHER'S MAIDEN NAME ALETHA BUCHANAN	
14. NAME OF HUSBAND OR WIFE JUANITA M. NELSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address MRS. JUANITA M. NELSON 2631 E. 10th.
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis DUE TO (b) Carcinoma of Pancreas DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 a.m. p.m. Month, Day, Year		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 <u>11-16-63</u> to <u>12-7-63</u> and last saw ^{her} him alive on <u>12-7-63</u> Death occurred at <u>11:40 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Hubert M. Parker M.D.		22b. ADDRESS 928 Arroyo Bldg	22c. DATE SIGNED 12-9-63
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 12-9-1963	23c. NAME OF CEMETERY OR CREMATORY FRY HILL CEMETERY	23d. LOCATION (City, town, or county) (State) LUCAS, IOWA
24. FUNERAL DIRECTOR ADDRESS C. H. BLACKMAN & SON, INC. K. C., MO.		25. DATE RECD. BY LOCAL REG. 12-9-63	26. REGISTRAR'S SIGNATURE Bessie Smith

USE BLACK INK OR TYPEWRITER RIBBON

14140-575

Dr. Parker
9 To 11 St
St. Marys

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 Hugh Baird

Licensed Embalmer No. 4888

P. O. Address 7c 24. 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.