

FILED JUL 1 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21676

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>100</u>		Registrar's No. <u>1388</u>		
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) b. STATE <u>Mo</u> c. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) <u>Koch Mo.</u>		c. LENGTH OF STAY (in this place township) <u>67 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		2189		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>4410 a Oakland</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>G.</u> c. (Last) <u>Nelson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6-14-54</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>6-27-13</u>		9. AGE (In years last birthday) <u>40</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Wayne County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Sare Nelson</u>			13b. MOTHER'S MAIDEN NAME <u>Pearl Page</u>		14. NAME OF HUSBAND OR WIFE <u>Gladys Nelson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>? unk</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Records of Robert Koch Hosp., Koch, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Peritonitis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>11 weeks</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Perforation of terminal ileum</u>							
	DUE TO (c) _____							
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pulmonary tuberculosis</u>							
19a. DATE OF OPERATION <u>3-29-54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Peritonitis, perforation of terminal ileum</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>4-8-1954</u> to <u>6-14-1954</u> , that I last saw the deceased alive on <u>6-14-1954</u> , and that death occurred at <u>3:55 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Archie R. Brown, M.D.</u>				23b. ADDRESS <u>Robert Koch Hospital</u>		23c. DATE SIGNED <u>6-14-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>6-15-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Rucker Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Greenville, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>6/15/54</u>		REGISTRAR'S SIGNATURE <u>Heather S. Embert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington.</u>				

(Licensed Embalmer's Statement on Reverse Side)

WHITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Student Embalmer

Signed *Robert M. Murray*

Licensed Embalmer No. *3749*

P. O. Address *St Louis 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 this body is not embalmed, fact should be so stated above.