MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

34049

1. PLACE OF DEATH.
County McDonald Registration District No. 518 File No. 1-1
Township McNatt Primary Registration District No. 5294 Registered No. 32
City Tiff City (No. ..... St. ..... Ward)

2. FULL NAME Abram Melkes

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word):

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 16 1845

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
82	6	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Old Veteran
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Prussia

PARENTS
10. NAME OF FATHER Don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) ?
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) ?

14. INFORMANT Mrs G Melkes
(Address) Tiff City Mo

15. FILED Nov 3, 1927 Andrew Mitchell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 3 1927

17. I HEREBY CERTIFY, That I attended deceased from July 14 1924, to Nov 2 1927, that I last saw him alive on Nov 2 1927, and that death occurred, on the date stated above, at 1:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Parenchymatous Nephritis complicated with Chronic Myocarditis
(5) 1926 (duration) ..... yrs. ..... mos. ..... ds
CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) A. M. Chase M D, M. D
Nov 5, 1927 (Address) Tiff City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Tiff City DATE OF BURIAL: 11/3 1927

20. UNDERTAKER: Norman E Melkes ADDRESS: Seneca

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St.

2. FULL NAME .....

(a) Residence. No.....St., ...Ward. .....
(Usual place of abode) (If nonresident give city

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DI

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended
.....,19....., to .....
that I last saw h..... alive on.....
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE O

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths fr
(1) MEANS AND NATURE OF INJURY, and (2) whether
HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

20. UNDERTAKER