

1928

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

Do not use this space.

1079-1

**1. PLACE OF DEATH**

County Golk  
Towship Johnson  
City Humansville (No. ....)

Registration District No. 709  
Primary Registration District No. 4024

File No. ....  
Registered No. 10  
St. .... Ward

**2. FULL NAME**

Melviney Souders

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode)

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS****3. SEX**

Female

**4. COLOR OR RACE**

W

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Married

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

abe Souders

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

1849-12-4

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>78</u>	<u>4</u>	<u>26</u>	

**8. OCCUPATION OF DECEASED**

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

Housewife

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

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

Ind.

(STATE OR COUNTRY)

**10. NAME OF FATHER**

James Morris

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

Ind.

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

unknown

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

unknown

(STATE OR COUNTRY)

**14.**

INFORMANT  
(Address)

Abe Souders

**15.**

FILED 3/31, 1928

D. Nevins  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** May 30 1928

**17.**

I HEREBY CERTIFY, That I attended deceased from mech 27, 1928, to mech 30, 1928, that I last saw her alive on mech 30, 1928, and that death occurred, on the date stated above, at 2:00 p.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pneumonia

(duration) yrs. mos. ds. 3 ds.

**CONTRIBUTORY (SECONDARY)**

(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical

(Signed) R. Nevins, M. D.

7/30, 1928 (Address) Humansville 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.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL****DATE OF BURIAL**

Souders Cemetery

3/31 1928

**20. UNDERTAKER****ADDRESS**

R.A. Joseph

3149

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.

DEPARTMENT RECORD

PHYSICIAN'S STATEMENT OF MEDICAL HISTORY

to be read in connection with the report of the physician who has examined the patient in the hospital.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Polk Registration District No. 78 B File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 4024 Registered No. \_\_\_\_\_  
 City Humansville (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Meloney Sanders  
 (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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 4 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
78 4 26

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Wagon  
 (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) \_\_\_\_\_

**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 3/4 19 28 Dr. Nevins  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 20 19 28

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pneumonia - Sebor

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) \_\_\_\_\_, M. D.

, 19 (Address) \_\_\_\_\_

\*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A SUPPLEMENTARY CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. EXAMINATION IS VERY IMPORTANT. EXAMINATION IS VERY IMPORTANT. EXAMINATION IS VERY IMPORTANT.

**SUPPLEMENTARY**

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