

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

Do not use this space.

17343

1. PLACE OF DEATH

County Buchanan
Township _____
City St. Joseph (No. 3217 Locust Street)

Registration District No. 1001

Primary Registration District No. _____

File No. _____
Registered No. 641
St. _____ Ward _____

2. FULL NAME Emma J. Melvin

(a) Residence. No. 3217 Locust Street St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

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

Married

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

William Melvin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 3, 1871

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1 day, _____ hrs. or _____ min.

57

11

12

B. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife

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

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Ottomwa

(STATE OR COUNTRY) Iowa

10. NAME OF FATHER Benjamin L Loper

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown

(STATE OR COUNTRY) Penn

12. MAIDEN NAME OF MOTHER Doris E Dennis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown

(STATE OR COUNTRY) Ohio

14. INFORMANT Wm Melvin

(Address) 3217 Locust Street

15. MAY FILED 17 1929 John L. [Signature] REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15 19 29

17. I HEREBY CERTIFY, That I attended deceased from
Apr 15 1929, to May 15 1929
that I last saw her alive on May 15 1929, and that death occurred, on the date stated above, at 11-10 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mycarditis (hr)
90 B 985
10 B 132 B
11 B (duration) yrs. 9 mos. ds.
CONTRIBUTORY Pneumonia (1 sept state)
(SECONDARY) menia (duration) yrs. 1 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) Dr. F. J. [Signature], M. D.

May 15 19 29 (Address) St. Joseph 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 Ashland Cemetery

DATE OF BURIAL May 18 19 29

20. UNDERTAKER H. O. Sidenlader

ADDRESS 1802 Union St

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

JUN 24 1929
6
9
2
2
2

