

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

Do not use this space.

2257

File No. 6
Registered No. _____
St. _____ Ward _____

PLACE OF DEATH

County Montana
Township North
City _____ (No. _____)

Registration District No. 609
Primary Registration District No. 5808

2. FULL NAME

Melvin Wayne Lanch
(a) Residence No. RRT 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH/DAY AND YEAR) Jan 17 1931

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) North RRT (STATE OR COUNTRY) Mo

10. NAME OF FATHER Bevil Lanch

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

12. MAIDEN NAME OF MOTHER Bernie Scritchfield

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

14. INFORMANT Bevil Lanch (Address) RRT North Mo

15. FILED 1/30 1931 C. E. Manss REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/20 1931

17. I HEREBY CERTIFY That I attended deceased from 1/19 1931 to 1/20 1931 that I last saw him alive on 1/19 1931, and that death occurred, on the date stated above, at 9:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature birth with intracranial pressure
16.5

159 (duration) yrs. mos. ds. CONTRIBUTORY (SECONDARY) 59 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

9 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Charles A. ... M. D.

, 19 (Address) North 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 Perce City Mo DATE OF BURIAL 1/26 1931

20. UNDERTAKER Byhavis ADDRESS North

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.

FEB 20 1931

