

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

Do not use this space.

AUG 16 1934

1. PLACE OF DEATH

County Reynolds Registration District No. 651
 Township Pratt Prairie Primary Registration District No. 6562
 City Joe Ellen Miles (No. _____) St. _____ Ward _____

File No. 21385
 Registered No. 85
 St. _____ Ward _____

2. FULL NAME

(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

Female

4. COLOR OR RACE

white

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

Widowed

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

✓

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

12-31-38

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hr. or _____ min.
0	5	29 29	

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). None
 (c) Name of employer None

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Miss

10. NAME OF FATHER

Eldon Miles

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ala.

12. MAIDEN NAME OF MOTHER

Wright Mason

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ala.

14.

INFORMANT

(Address) Eldon Miles
Caretsville Mo

15.

FILED July 7, 1934

Ada Martin
REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

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

6-29 1934

17.

I HEREBY CERTIFY, That I attended deceased from 6/16 1934 to 6/29 1934 that I last saw him alive on 6/28 1934, and that death occurred, on the date stated above, at noon m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meta static meningitis
23A
99A

CONTRIBUTORY (SECONDARY)

Colitis (acute)
(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) J. A. M. Sweeney M. D.

July 7, 1934 (Address) Caretsville 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

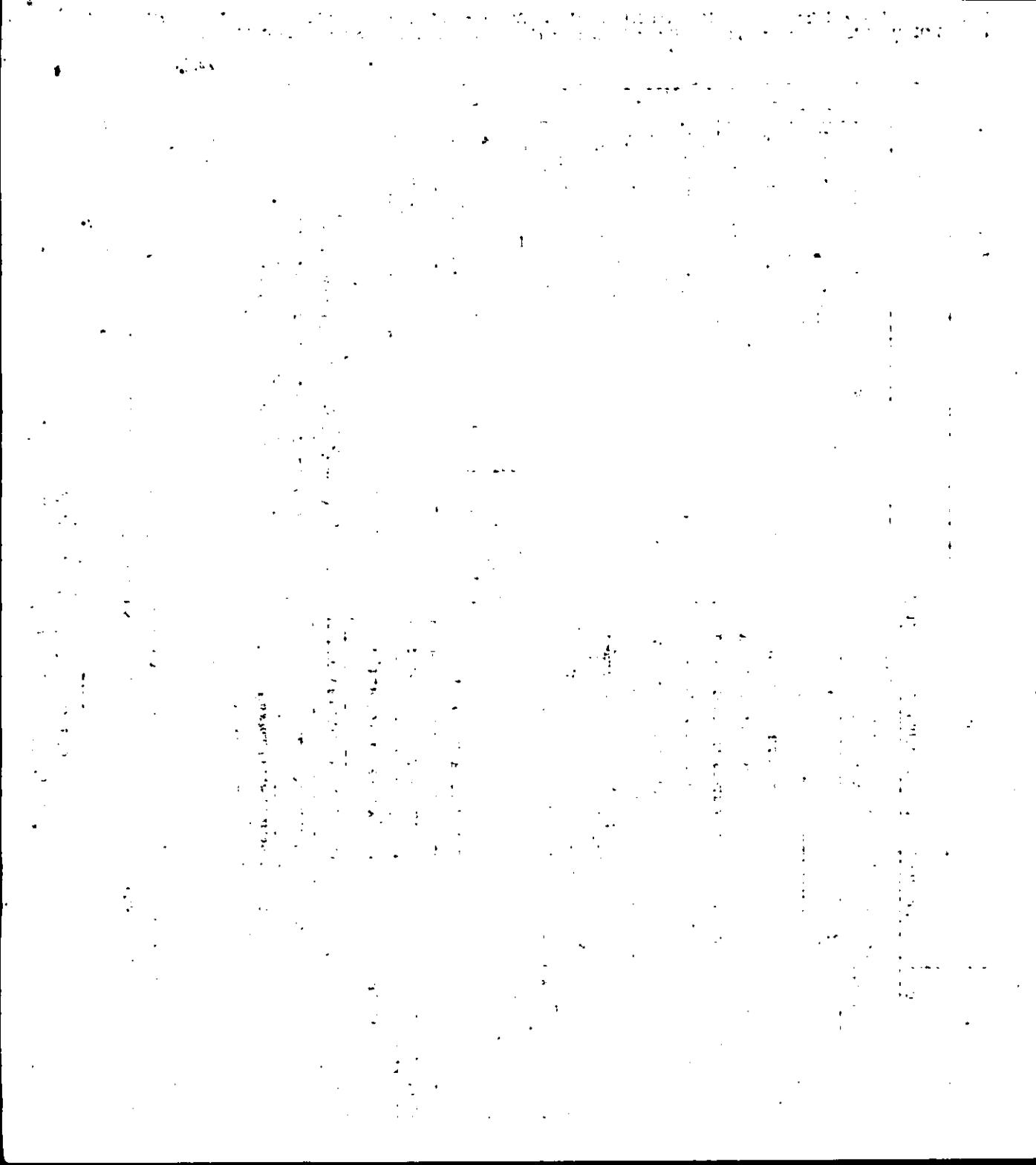
Coater No 8 cemetery 6/30 1934

20. UNDERTAKER

ADDRESS

H. S. Smith
Caretsville Mo

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.



Permeat

WASHINGTON

21385

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Joe Ellen Meles
Who died at _____ on June 29 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex F Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 4 Months 5 Days 28

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) Tennessee
Birthplace of mother (State or country) _____
Principal cause of death: _____

Other contributory causes of importance Colitis acute
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____

X Signature of Registrar Lida Martin Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 651 Very truly yours,
Primary Reg. Dist. No. 5862
E. T. McLaugh
State Registrar
Special Agent.

S-21385

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