

REC'D FEB 15 1939

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

2376
Do not use this space.

1. PLACE OF DEATH
(a) County Greene Registration District No. 318
(b) Township Springfield Primary Registration District No. 5439
(c) City Springfield (d) Street No. R. # 2 Registered No. 6
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME JAMES N. MELTABARGER.
(a) Residence, No. R. # 2 St. (If nonresident, give city or town and State) R # 2
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX MALE 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 Zora E. Meltabarger
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 3 - 1883
7. AGE YEARS 55 MONTHS 1 DAYS 28 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Truck Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. on farm
10. Date deceased last worked at this occupation (month and year) Jan 1 1938 Total time (years) spent in this occupation 1

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1 1939
22. I HEREBY CERTIFY, That I attended deceased from Dec 31 1938 to Jan 1 1939
I first saw him alive on Dec 31 1938. Death is said to have occurred on the date stated above, at 11:50 a.m.
The principal cause of death and related causes of importance were as follows:
Apoplexy
Hypertension
Date of onset 6/1/38
Other contributory causes of importance:
Arterio Sclerosis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Mo.
13. NAME Lafayette Meltabarger
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jenin Mo.
15. MAIDEN NAME Elizabeth Vaughn
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
17. INFORMANT (ADDRESS) Zora E. Meltabarger R# 2 Springfield Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE East Lawn DATE Jan. 4 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. Whigmore & Co. Springfield Mo.
20. FILED Jan 3 1939 Class A George M. Local Registrar.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
23. 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 _____
24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) A. E. Feller, M. D.
(Address) Springfield Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. HOW should be stated EXACTLY.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No. *3358*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.