

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.

DEC 15 1939  
#497 334  
Registration District No. #497 334

Primary Registration District No. 497

Registrar's No. 70

1. PLACE OF DEATH: 2  
(a) County HARRISON  
(b) City or town Bethany  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 67 years (Specify whether years, months or days) 1111

2. USUAL RESIDENCE OF DECEASED: 1  
(a) State Missouri (b) County HARRISON  
(c) City or town Bethany  
(If outside city or town limits, write "RURAL")  
(d) Street No. West Central St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ✓ \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Jessie Armida Melvin  
3. (b) If veteran, ✓ name war \_\_\_\_\_ 3. (c) Social Security No. ✓  
4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife G. E. Melvin 6. (c) Age of husband or wife if alive ✓ \_\_\_\_\_ years  
7. Birth date of deceased 7 13 1872  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 4  
year 1939 hour 10 AM minute \_\_\_\_\_ A. M.  
21. I hereby certify that I attended the deceased from Oct 13-1939  
1839 to Nov 4th, 1939  
that I last saw her alive on Nov 3rd, 1939; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
67 3 23 ✓ hr. ✓ min.

Immediate cause of death Acute Parenchymatous Nephritis from Oct 13, 1939 to Nov 4-1939. Duration 3 wks  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Bethany Missouri  
(City, town or county) (State or foreign country)  
10. Usual occupation house work  
11. Industry or business when younger DePaul  
12. Name W. S. Gindmerlee  
13. Birthplace Ind.  
(City, town or county) (State or foreign country)  
14. Maiden name Ernest High  
15. Birthplace Davies Co. Mo.  
(City, town or county) (State or foreign country)

Other conditions Organic Heart trouble (enlarged)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant's own signature Bettie A Robertson  
(b) Address New Cambria Mo.  
17. (a) Burial (Burial, cremation, or disposal) (b) Date thereof 11-6-39  
(Month) (Day) (Year)  
(c) Place: burial or cremation Missionary Cemetery  
18. (a) Signature of funeral director J. W. Haas  
(b) Address Bethany Mo  
19. (a) 11-7-39 (Date received local registrar) (b) A. F. Weisler (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature R. M. Deeds D.O. (M.D. or other) \_\_\_\_\_  
Address Bridgeman 7th Date signed Nov 6 1939

956 2

311

... No. 11;  
1239-1675  
DEC 5  
1939

**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.....  
P. O. Address.....

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

397227  
Do not use this space.

1. PLACE OF DEATH

(a) County Harrison Registration District No. 334  
(b) Township Bethany Primary Registration District No. 4197 Registered No. 70  
(c) City Bethany (d) Street No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(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 Jessie Armilda Melvin

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 4 1939

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

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

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the \_\_\_\_\_ at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
67 3 23

The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

acute parenchymatous nephritis from Oct 13 to Nov 4.  
Chronic Heart trouble  
Other contributory causes of importance: \_\_\_\_\_  
Chronic form existed probably two or three years

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

FATHER 13. NAME \_\_\_\_\_

FATHER 14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME \_\_\_\_\_

MOTHER 16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) R. H. Beets M. D.  
(Address) R. Ridgeway Mo.

Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENT

