DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JUL 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21257

Registration District No. 85 | Primary Registration District No. 1001 | Registrar's No. 662

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph 2
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 509 Alabama Street,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
In this community 3 years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits write "RURAL")

(d) Street No. 509 ALABAMA ST.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 34 years.

3. (a) PRINT FULL NAME Sister Mary Melchiada 423

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 19 (Day) 1880 (Year)

8. AGE: Years 60 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) Poland (State or foreign country)

10. Usual occupation Teacher (Religious) 7

11. Industry or business Catholic Church

FATHER
12. Name John Melchiada 7
13. Birthplace Unknown (City, town, or county) Poland (State or foreign country) 7

MOTHER
14. Maiden name Emilia Miller
15. Birthplace Unknown (City, town, or county) Poland (State or foreign country)

16. (a) Informant Sister M. Zachea
(b) Address Chicago, Ill.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation My. Olivet Cemetery.

18. (a) Signature of funeral director Herman Wm. Sidenfaden
(b) Address 1802 Union Str. St. Joseph, Mo.

19. (a) 6/18/40 (Date received local registrar) (b) H J Mastlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17th year 1940 hour 5 minute 30 A M.

21. I hereby certify that I ~~attended~~ viewed the deceased from June 17th, 1940 to , 19 ;
that I last saw h~~ill~~ ~~alive~~ on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency | Duration

Due to 92 W

Due to

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

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? 85 (Specify type of place)
While at work? (e) Means of injury

23. Signature B. W. Tadlock Coroner (M. D. or other) 5
Address King Hill Bldg Date signed 6/17/40

(Licensed Embalmer's Statement on Reverse Side)

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 Elbert R. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, Mo.

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

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