

No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 8 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

25421

State File No. _____

Registration District No. 411

Primary Registration District No. 2002

Registrar's No. _____

1. PLACE OF DEATH: Jasper
 (a) County: Jasper
 (b) City or town: Joplin
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Johns Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: 50 Years; (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Frank Sherman Melton;
 3. (b) If veteran, name war: No
 3. (c) Social Security No.: No

4. Sex: Male
 5. Color or race: White
 6. (a) Single, widowed, married, divorced: Married
 6. (b) Name of husband or wife: Ella
 6. (c) Age of husband or wife if alive: 70 years
 7. Birth date of deceased: Sept 15, 1864
 (Month) (Day) (Year)

8. AGE: Years: 75 Months: 10 Days: 16 If less than one day: _____ hr. _____ min.

9. Birthplace: Greenfield Indiana.
 (City, town, or county) (State or foreign country)

10. Usual occupation: Mattress Maker
 11. Industry or business: Joplin Mattress Co

MOTHER FATHER
 12. Name: FRANCIS M MELTON
 13. Birthplace: GREENFIELD IND
 (City, town, or county) (State or foreign country)
 14. Maiden name: CYNTHIA COMPTON
 15. Birthplace: GREENFIELD IND
 (City, town, or county) (State or foreign country)

16. (a) Informant: John Melton
 (b) Address: 2021 main Joplin Mo

17. (a) Burial (b) Date thereof: Aug. 1, 40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mt Hope.
 18. (a) Signature of funeral director: Hurlbut Und. Co;
 (b) Address: Joplin Missouri.

19. (a) 8-1-40 (b) Ed D James
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Mo; (b) County: Jasper
 (c) City or town: Joplin Mo;
 (If outside city or town limits, write "RURAL")
 (d) Street No.: 2021 Main Street.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? No years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 30 day 1940
 year _____ hour 8-00 P.M. minute _____ M.
 21. I hereby certify that I attended the deceased from 7-29-40
 _____, 19 _____ to _____, 19 _____
 that I last saw him alive on 7-30, 19 40
 and that death occurred on the date and hour stated above.

Immediate cause of death: Heart Failure
 Due to: Chr. nephritis
 Due to: _____
 Other conditions: _____
 (Include pregnancy within 3 months of death)

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

Major findings:
 Of operations: _____
 Of autopsy: _____

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? 372
 (Specify type of place) _____
 While at work? _____ (e) Nature of injury: _____
 23. Signature: [Signature] (M. D. or other) _____
 Address: 616 Francis Bldg Date signed: 8-1-40

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

40-8-291

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 Steve D. Parker

Licensed Embalmer No. 25748

P. O. Address 20th 14th

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, fact should be so stated above.