

Registration District No. 502

Primary Registration District No. 4305

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Marceline
(If outside city or town limits, write "RURAL" and name of township)
(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 2
(Specify whether
In this community 52 yrs
years, months or days)

3. (a) PRINT FULL NAME Melvina M Hemmings

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 married
6. (b) Name of husband or wife Joseph Hemmings 6. (c) Age of husband or wife if alive 92 years
Birth date of deceased Oct 17 1857
(Month) (Day) (Year)

8. AGE: Years 82 Months 11 Days 22 If less than one day hr. _____ min. _____

9. Birthplace Sigourney Ia.
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

12. Name Hiram McConnell

13. Birthplace don't know
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Malcolm

15. Birthplace don't know
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Geo. A. Smith

(b) Address Joplin Mo

17. (a) Burial (b) Date thereof Oct 12 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet

18. (a) Signature of funeral director James McLaughlin

(b) Address Marceline Mo

19. (a) 11-12-40 (b) Clara Barrett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln
(c) City or town Marceline Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9
year 1940 hour 11 minute 50 P.M.

21. I hereby certify that I attended the deceased from June
1937, to Oct 9, 1940;
that I last saw her alive on Oct 9, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 3 hrs

Due to _____

Due to _____

Other conditions Cerebral Hemorrhage Painful
(Include pregnancy within 3 months of death)

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?
Yes

While at work? _____ (Specify type of place)
(a) Means of injury _____

23. Signature J. P. Putman (M. D. or other) M.D.

Address Marceline Mo Date signed Oct 16

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.

822

OCT 18 1940

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 Dale Benish
Licensed Embalmer No. 4088
P. O. Address Marceline Mo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35738**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **202**

Primary Registration District No. **4305**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Lin

(b) City or town Marceline
(If outside city or town limits, write "RURAL" and name of township)

(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, years, months or days)

3. (a) **PRIN FULL NAME** Melvin M. Hemming

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

5. Color or race W

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

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. **AGE:**

Years	Months	Days	If less than one day
<u>82</u>	<u>11</u>	<u>22</u>	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits write "RURAL")

(d) Street No. _____
(If rural, give location)

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct day 7
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration _____
Bronchial Pneumonia

Due to _____
Due to _____
Other conditions Cerebral Hemorrhage
(Include pregnancy, within 3 months of death)

Major findings: Paralytic

Of operations _____

Of autopsy _____

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? _____

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

23. Signature [Signature] (M. D. or other) MD

Address Marceline Mo Date signed 12/12/40

SUPPLEMENTAL REPORT

