

Registration District No. 547Primary Registration District No. 3029

Registrar's No.

152

## 1. PLACE OF DEATH:

- (a) County Marion  
 (b) City or town Harrison  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St Elizabeth Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 week (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME Mary Melaga

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 Max Tit 6. (c) Age of husband or wife if alive 66 years  
 7. Birth date of deceased Dec. 14, 1877  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
63 4 21 hr. min.

9. Birthplace Austria-Hungary  
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

- MOTHER FATHER  
 12. Name John Duplak  
 13. Birthplace Unknown (City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Martin Melaga  
 (b) Address Glass, Mo  
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8-1941  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation St Mary Cem

18. (a) Signature of funeral director James O'Hanlon  
 (b) Address Harrison Mo  
 19. May 12, 1941 (Date received local registrar) (b) W. C. Fisher (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Rolls 87  
 (c) City or town Thasco 0  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6  
year 1941 hour \_\_\_\_\_ minute 3 1/2 A.M.21. I hereby certify that I attended the deceased from April 15 1941 to May 6 1941  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.Immediate cause of death Bilateral lower lobe  
pneumonia ✓  
Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chromydia  
(Include pregnancy within 3 months of death)Major findings: None  
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?  
480 (Specify type of place) (e) Month of injury \_\_\_\_\_

23. Signature John Fisher (M. D. or other) \_\_\_\_\_  
Address Harrison Mo Date signed 5/11/41

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**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 Michael J. Johnson

Licensed Embalmer No. 3246

P. O. Address Hannibal, MO

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

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18386

Registration District No. 547

Primary Registration District No. 3229

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Mason  
(b) City or town Wasson  
(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) PRINT FULL NAME Mary Melara

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 68 Months 4 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (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) Citizen of foreign country \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6  
year 1941 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 Bilateral lobar Duration \_\_\_\_\_  
lobes pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chr. Myo Carditis  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

