

No. 2
-2-43
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31162**

Registration District No. **3006**

Primary Registration District No. **5720**

Registrar's No. **226**

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

1. PLACE OF DEATH:

(a) County **Boone**

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

(c) Name of hospital or institution: **Boone Co Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: in hospital or institution **6 Days**
(Specify whether **Life**)

In this community **Life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Boone**

(c) City or town **Columbia**
(If outside city or town limits, write "RURAL.")

(d) Street No. **1400 Richardson**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **v**

3. (a) PRINT FULL NAME **WALTER Melloway**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **486-20-3756**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **24th**
year **1943** hour **1:45** minute **A.** M.

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Pearl Grooms Melloway**

6. (c) Age of husband or wife if alive **44** years

7. Birth date of deceased **Sept 24 - 1899**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept-11-1943** to **Sept-15-1943**
that I last saw him alive on **Sept-14-** 1943
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic nephritis -**

8. AGE: Years **65** Months **11** Days **21**
If less than one day hr. min.

Due to **121 h**

9. Birthplace **Boone Co Mo**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **Painter**

Major findings: Of operations **none**

11. Industry or business

Of autopsy **none**

12. Name **Theresa Melloway**

PHYSICIAN

13. Birthplace **Boone Co Mo**
(City, town, or county) (State or foreign country)

Underline the cause to which death should be charged statistically.

14. Maiden name **Nancy Walker**

15. Birthplace **Boone Co MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Pearl Melloway**

(b) Address **1400 Richardson**

17. (a) **Burial** (b) Date thereof **Sept 26-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Nashville, Tenn**

18. (a) Signature of funeral director **R. P. Bennett**

(b) Address **Columbia Mo**

19. (a) **Sept 23-43** (b) **Edna H. Barber**
(Date received local registrar) (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 **J. C. Suggitt** (M. D. or other) **M.D.**

Address **Columbia** Date signed **9/24/43**

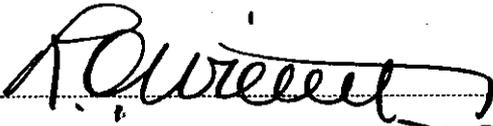
1256

(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..... .....

Licensed Embalmer No..... 3183

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, fact should be so stated above.