

FILED AUG 14 1944

Registration District No. 204

Primary Registration District No. 5863

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Couch Oak Grove Twsp.
(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 1
(Specify whether

In this community
years, months or days)

3. (a) PRINT FULL NAME S. D. Melton

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Laura Williams 6. (c) Age of husband or wife if alive 80 years

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

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

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Elzie Melton

(b) Address Couch, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/44
(Month) (Day) (Year)

(c) Place: burial or cremation Myrtle, Mo.

18. (a) Signature of funeral director None

(b) Address

19. (a) 7-14-44 (Date received local registrar) (b) Zae D. Williams (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75

(c) City or town Couch (Rural) (If outside city or town limits, write "RURAL") 0

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

(e) Citizen of foreign country? (Yes or No) 0
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11
year 1944 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from May 10
1944, to June 11 1944

that I last saw him alive on June 2 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia
Pylo Hepatitis

Due to Smoking

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 133a

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?

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

23. Signature [Signature] (M. D. or other) 0
Address Myrtle, Mo Date signed 7-1-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 33

District File Number 844438

Date Filed 8-12-44

APR 11 1944

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.....

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.

Registration District No. 254

Primary Registration District No. 5863

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Couch Beach
(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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME S. D. Melton

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

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

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation same

11. Industry or business _____

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) Zae W. Williams
(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 _____ year 1944 day _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____

that I last saw him _____ alive on _____, 19____

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions: _____
(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? _____

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

MOTHER FATHER

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

AUG 1944

4/1/69

25345