

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

35524
Do not use this space.

FILED NOV 10 1944

1. PLACE OF DEATH

(a) County Texas Registration District No. 355
 (b) Township Perice Primary Registration District No. 6205 Registered No. _____
 (c) City 1 (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MELVIN LEE BELTZ

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 2 hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clear Springs, Mo.

FATHER 13. NAME Le Roy Beltz

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Culver, Kan.

MOTHER 15. MAIDEN NAME Irene Dixon

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Quind, Mo.

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Clear Springs DATE Oct. 26 1944

19. FUNERAL DIRECTOR (ADDRESS) Elmer Beltz
Willon Springs Mo.

20. FILED Nov 2 1944 Mrs Paul Riley
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 26 1944

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to Oct. 26, 1944
 I last saw h. _____ alive on _____, 1944. Death is said to have occurred on the date stated above, at 4: A. m.

The principal cause of death and related causes of importance were as follows:

8 month baby premature lived 2 hours born at 2:00 AM died 4:00

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify: (Signed) Mrs. Harriett Kayt
 (Address) Summersville, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1847

RECEIVED

District Health Officer No. 5,

District File Number.

1144555

Date Filed

11-8-44

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No.

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.)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 35520Registration District No. 255Primary Registration District No. 6205

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Texas
 (b) City or town Peucedon
 (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 Melvin L. Beltz

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 S

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

7. Birth date of deceased
- Oct 26 1948
-
- (Month) (Day) (Year)

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

9. Birthplace
- MO
-
- (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 _____

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) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- Oct
- Day
- 26
- Year
- 1948
- Hour _____ minute _____ M.

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

that I last saw him/her alive on _____, 19____;

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

Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____ (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) _____ (c) Means of injury _____

23. Signature
- Dr. Paul Kelly
- (M. D. or other) _____

Address Summersville, Mo. Date signed _____

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

MOTHER FATHER

[The page contains extremely faint and illegible text, likely bleed-through from the reverse side of the document. The text is too light to transcribe accurately.]