

**FILED FEB 15 1946 STANDARD CERTIFICATE OF DEATH**

State File No.

**3024**Registration District No. 157Primary Registration District No. 5588

Registrar's No.

5**1. PLACE OF DEATH:**

(a) County Jasper  
 (b) City or town rural - Sarcoxie Twonship  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Reeds, Mo., Route 1 /  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
 In this community 61½ years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Casimer Melin

3. (b) If veteran, name war none  
 3. (c) Social Security No. none

4. Sex male 5. Color or race white  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Nellie Hood Melin  
 6. (c) Age of husband or wife if alive 57 years  
 7. Birth date of deceased February 23 1874  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>10</u>	<u>21</u>	hr. _____ min.

9. Birthplace Osage County Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation farmer11. Industry or business ----

MOTHER FATHER { 12. Name Victor Melin  
 13. Birthplace unknown France  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Clenentine Vaughn  
 15. Birthplace unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Casimer Melin(b) Address Route 1, Reeds, Mo.17. (a) burial (b) Date thereof Jan 16, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Williams Cemetery18. (a) Signature of funeral director Knell Mortuary(b) Address Carthage, Mo.19. (a) 1-14-46 (b) R.B. Clinton, MD  
(Date received local registrar) (Registrar's signature)**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jasper  
 (c) City or town rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Reeds, Mo., Route 1  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country.....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan day 14  
 year 1946 hour 9 minute a M.

21. I hereby certify that I attended the deceased from  
January 1940 to Jan 14 1946  
 that I last saw him alive on Jan 14 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death.

Cardio vascular - remo  
heart failure

Due to

congestive heart

Due to

Other conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations

Of autopsy

Duration

**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 Geo. H. Brazdon (M. D. or other)Address Reeds, Mo. Date signed 1/19/46

46-1-31

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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.....

*Emm L. Trues*

Licensed Embalmer No.....

391

P. O. Address.....

*Carthage*

**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. 157 Primary Registration District No. 5588

**1. PLACE OF DEATH:**  
 (a) County Jasper  
 (b) City or town Rural Lawrenceburg  
(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 years, months or days)

**3. (a) PRINT FULL NAME** Cassimer Melvin  
 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 w  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Feb 23 1947  
(Month) (Day) (Year)

**8. AGE:** Years 21 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day, 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)** 1-14-46 **(b)** L. B. Clinton, D.  
(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 \_\_\_\_\_ Day \_\_\_\_\_  
 year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_, 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

1404

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1700

1700

3024