

No. 2
2-43
35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20967**
Registrar's No. **78**

FILED JUN 26 1945
Registration District No. **278**

Primary Registration District No. **5789**

1. PLACE OF DEATH:

(c) County **Mississippi**
(d) City or town **Anniston, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(e) 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 **40 yrs** years, months or days)

3. (a) PRINT FULL NAME **SAMUEL BOONE 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 **Floyd Melton** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **Feb 14 1884**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 4 14 hr. min.

9. Birthplace **Union Co. Kentucky**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business **Farmer**

12. Name **Alex Green Melton**

13. Birthplace **Union Co. Ky**
(City, town, or county) (State or foreign country)

14. Maiden name **Alice Murchhead**

15. Birthplace **Union Co. Ky**
(City, town, or county) (State or foreign country)

16. (a) Informant **W. G. Melton**

(b) Address **Anniston Mo.**

17. (a) **Burial** (b) Date thereof **6-30-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Anniston, Mo.**

18. (a) Signature of funeral director **Frank Shelly**

(b) Address **Last Prairie, Mo.**

19. (a) **6-3-46** (b) **Gertrude H. Harper**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **28**
year **1945** hour **9** minute **20 A.** M.

21. I hereby certify that I attended the deceased from **June 28 1945** to **June 28 1945**
that I last saw him alive on **June 28 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Paralytic Stroke** Duration **2 days**

Due to.....
Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....
Of autopsy **122**

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 **G. P. Penton** (D. of other) **JD**
Address **Wyaat Mo.** Date signed **6-6-45**

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

MOTHER FATHER

171

RECEIVED

District Health Office No. _____

District File Number 646-72

Date Filed 6-12-4

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 Travis Shelby

Licensed Embalmer No. 272

P. O. Address East Prairie, Mo

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

July
788

Registration District No.

218

Primary Registration District No.

5789

Registrar's No.

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Anderson
(c) Name of hospital or institution: S. J. P.

(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

Samuel B. 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 _____

7. Birth date of deceased Feb 14 (Month) (Day) (Year)8. AGE: Years 61 Months 4 Day _____ (less than one day) hr. _____ min.

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

10. Usual occupation Labor11. Industry or business Farm

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) 6-25-46 (b) Gertrude G. Harper (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 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY 5

20967