

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

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DEPARTMENT OF COMMERCE  
HEALTH OF MISSOURI  
FILED APR 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14205  
Registrar's No. 151

Registration District No. 209 Primary Registration District No. 3043

1. PLACE OF DEATH:  
(a) County MARION  
(b) City or town HANNIBAL  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
ST. ELIZABETH HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 DAYS  
In this community 10 Days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County MARION 64  
(c) City or town MONROE CITY /  
(If outside city or town limits, write "RURAL")  
(d) Street No. 401 STODDARD 0  
(If rural, give location)  
(e) Citizen of foreign country? NO / (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME ALBERT ALEXAS MELSON  
3. (b) If veteran, name war /  
3. (c) Social Security 489-26-9963

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month APRIL day 10th  
year 1947 hour 1 minute 10 P.M.  
21. I hereby certify that I attended the deceased from June 1, 1947, to April 10, 1947  
that I last saw him alive on April 10, 1947  
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife LOUISE  
6. (c) Age of husband or wife if alive 67 years  
7. Birth date of deceased OCTOBER 11 1879  
(Month) (Day) (Year)

Immediate cause of death Severe abdominal Duration ?

8. AGE: Years Months Days If less than one day  
67 5 30 hr. min.

Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death)

9. Birthplace RALLS COUNTY MISSOURI  
(City, town, or county) (State or foreign country)  
10. Usual occupation FILLING STATION OPERATOR OWN STATION

Major findings:  
Of operations  
Of autopsy

MOTHER FATHER

12. Name JOEL MELSON  
13. Birthplace MISSOURI  
(City, town, or county) (State or foreign country)  
14. Maiden name DONT KNOW  
15. Birthplace DONT KNOW  
(City, town, or county) (State or foreign country)

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?  
(Specify type of place) (e) Means of injury

16. (a) Informant Mrs Louise Melson  
(b) Address Detroit Michigan  
17. (a) BURIAL (b) Date thereof 4/12/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. JUDES MONROE CITY  
18. (e) Signature of funeral director Wilson & Sows  
(b) Address MONROE CITY; MO  
19. (a) 4-15-47 (b) W. L. M. Lucke  
(Date received local registrar) (Registrar's signature)

ADDITIONAL SUPPLEMENTARY INFORMATION FOR DEATH CERTIFICATE REQUESTS should be charged statistically.

20 April 2-47

**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 *mw*.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *Leslie L. Wilson*.....

Licensed Embalmer No. *3014*.....

P. O. Address *Blount County, TN*.....

**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. 209 Primary Registration District No. 3043

1. PLACE OF DEATH:

(a) County marion  
(b) City or town Hammel  
(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) (Specify whether

3. (a) PRINT FULL NAME Albert A. Nelson

3. (b) If veteran, \_\_\_\_\_ 3. (c) Social Security  
number war \_\_\_\_\_ 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 oct. 11  
(Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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) \_\_\_\_\_ (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 April  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to Stroke

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 46F

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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

14205