

FILED SEP 13 1948

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **942**

1. PLACE OF DEATH:
(a) County **Buchanan County**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital no 2 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 yrs 3 mo 26 days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Melvina Miller**
3. (b) If veteran, name war **—** 3. (c) Social Security No. **—**

4. Sex **Female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **not given** 6. (c) Age of husband or wife if alive **8** years
7. Birth date of deceased **July 8 1905**
(Month) (Day) (Year)

8. AGE: Years **43** Months **1** Days **26** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

MOTHER { 12. Name **Bliss Martindale**
13. Birthplace **unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **Ester Bush**
15. Birthplace **unknown** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Ester Martindale**
(b) Address **St Joseph Mo 1513 No 119**
17. (a) **Burial** (b) Date thereof **9/7/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **E.O.O.F. Cemetery**
18. (a) Signature of funeral director **John C. Keefe**
(b) Address **6054 Pryor Ave, City**
19. (a) **9-7-48** (b) **E. B. Jenkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Andrew** 2
(c) City or town **Paxsonah** 1
(If outside city or town limits, write "RURAL")
(d) Street No. **09**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **4** 9
year **1948** hour **11** minute **05 A.M.**

21. I hereby certify that I attended the deceased from **Aug 1** 1948, to **Sept 4** 1948;
that I last saw her alive on **Sept 4** 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death **Diphtheritic meningococcal meningitis** Duration

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **200**
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 **James J. Hornes** (M.D. or other)
Address **St Joseph Mo** Date signed **9/4-48**

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.....

Grandal A. Stase

Registered Apprentice No.....

working under my personal supervision.

Signed.....

John E. King

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.