

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Rural Park
(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 LAMONA SUE MELLON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced /

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

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

8. AGE: Years _____ Months _____ Days 2 If less than one day hr. _____ min. _____

9. Birthplace Ray Co Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Frank Mellon

13. Birthplace Union Star Mo
(City, town, or county) (State or foreign country)

14. Maiden name Louise Sharp

15. Birthplace Ray Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Mellon

(b) Address Lawson Mo

17. (a) Buried (b) Date thereof Dec 30 '48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawson Cemetery

18. (a) Signature of funeral director J. J. Richardson

(b) Address Lawson Mo

19. (a) Dec 30 1948 (b) Mrs. Raymond Moore
(Date received local registrar) (Registrar's signature) (Date)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray
(c) City or town Rural Park
(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 Dec day 28
year 1948 hour 8 minute PM

21. I hereby certify that I attended the deceased from Dec 26, 1948
to Dec 28, 1948
that I last saw her alive on Dec 28, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage
Card Hemorrhage
Due to Hemorrhagic Diathesis
probably R. H. factor
Due to which had not been
indicated

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____
Of autopsy 1600

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 Dr. J. J. Richardson (M. D. or other) _____
Address Lawson Mo Date Dec 30, 1948

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-11-49

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 E. White

Licensed Embalmer No. 4168

P. O. Address Excelsior Springs, 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.