No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 17 1949

State File No. 8876

BIRTH NO. _____ REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 3127 Registrar's No. 49

1. PLACE OF DEATH
a. COUNTY Jasper
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Webb City
c. LENGTH OF STAY (in this place) 15 min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jane Chinn Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Jasper
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Webb City
d. STREET ADDRESS (If rural, give location) 212 South Tom Street

3. NAME OF DECEASED (Type or Print)
a. (First) Melissa
b. (Middle)
c. (Last) Hann

4. DATE OF DEATH (Month) (Day) (Year) March 3, 1949

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH April 2, 1866
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR: Months 11, Days 1 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Camdon County Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME F. B. Hunter
13b. MOTHER'S MAIDEN NAME Calperna Carter
14. NAME OF HUSBAND OR WIFE Gus Hann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME Mrs. Ethel Lomax — ADDRESS Cherryvalle, Kan.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pernicious Anemia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-6 *1948, to* 3-3-49 *, 19___, that I last saw the deceased alive on* 3-3-49 *, 19___, and that death occurred at* 8:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature] DO. 2
23b. ADDRESS Carterville, Mo.
23c. DATE SIGNED 3-5-49

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 3-7-49
24c. NAME OF CEMETERY OR CREMATORY MT HOPE
24d. LOCATION (City, town, or county) WEBB CITY (State) MO.

DATE REC'D BY LOCAL REG. MCH 5, 1949
REGISTRAR'S SIGNATURE [signature] 137
25. FUNERAL DIRECTOR'S SIGNATURE Hedge-Lewis Funeral Home — ADDRESS Webb City, Mo.

(Licensed Embalmer's Statement on Reverse Side) [signature]

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

49-3-190

Pence

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 .....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Richard Gray Lewis

Licensed Embalmer No. 4405

P. O. Address Webb City, 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.