

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39056

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10367

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2153 Russell		d. STREET ADDRESS (If rural, give location) 23 2153 Russell	

3. NAME OF DECEASED a. (First) Melissa		b. (Middle) J.		c. (Last) Medley		4. DATE OF DEATH (Month) (Day) (Year) Dec. 1, 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH July 19, 1868		9. AGE (In years last birthday) 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Shannon Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Mathew Hurt		13b. MOTHER'S MAIDEN NAME Katherine Malugin		14. NAME OF HUSBAND OR WIFE Thomas Medley	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Sam Medley		ADDRESS 2153 Russell	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Cerebral Hemorrhage				1 year	
ANTECEDENT CAUSES		Arteriosclerosis				15 yr	
MORIBUND 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		Chronic Nephritis				2	
Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X	
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22. I hereby certify that I attended the deceased from 10-28, 1949, to 12-1, 1949, that I last saw the deceased alive on 11-28, 1949, and that death occurred at 10:05 a. m., from the causes and on the date stated above.

23a. SIGNATURE J. B. Lasater (Degree or title)		23b. ADDRESS 3306 - So 13th St. St. Louis Mo		23c. DATE SIGNED Dec. 1-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-1-49		24c. NAME OF CEMETERY OR CREMATORY Mt. Zion		24d. LOCATION (City, town, or county) (State) Winona, Mo.	
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DATE REC'D BY LOCAL REG. DEC 1 1949		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington Blvd.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Murray

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 *Robert M Murray*

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, 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.