

FILED NOV 25 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36015

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 0 PRIMARY REG. DIST. NO. 3000 Registrar's No. 306

1. PLACE OF DEATH a. COUNTY <u>Madair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>SULLIVAN</u>	
b. CITY (If outside corporate limits, write BURIAL and give township) <u>Kirksville</u>		c. CITY (If outside corporate limits, write BURIAL and give township) <u>Green City</u> <u>1050</u>	
c. LENGTH OF STAY (In this place) <u>7 days</u>		d. STREET ADDRESS (If rural, give location) <u>NO STREET ADDRESS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Community Nursing Home</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>DELPAINA</u>	b. (Middle)	c. (Last) <u>MELSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 13 1950</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 3, 1974</u>	9. AGE (In years last birthday) Months Days <u>76</u>	IF UNDER 1 YEAR Hours Min.	IF UNDER 24 HOURS Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARM HOME</u>	11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u> <u>0</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>CLIFTON THOMPSON SCOTT</u>	13b. MOTHER'S MAIDEN NAME <u>PHOEBE ANN MALONE</u>	14. NAME OF HUSBAND OR WIFE <u>LOUIS MELSON</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>CHARLES SCOTT, GREEN CITY, MO.</u>	ADDRESS
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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 <u>30 min.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory Failure</u>		7 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Hemorrhage</u>		
DUE TO (c) <u>Arteriosclerotic hypertension</u>		10 yrs.	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>		321X	

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?
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22. I hereby certify that I attended the deceased from Nov 6, 1950, to Nov 13, 1950, that I last saw the deceased alive on Nov 12, 1950, and that death occurred at 4:10 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Vincent J. Strangio</u> (Degree or title) <u>D.O.</u>	23b. ADDRESS <u>KIRKSVILLE, MO.</u>	DATE SIGNED <u>Nov 13, 1950</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>NOV. 15, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>GREEN CITY CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>GREEN CITY, MO.</u>
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DATE REC'D BY LOCAL REG. <u>11-13-50</u>	REGISTRAR'S SIGNATURE <u>Kate Lambert 'o</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn E. Kent &amp; Son, Green City, Mo.</u>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

00134

JUL 14 1954

NOV 22 1954

Date Received: NOV 22 1954  
DISTRICT HEALTH OFFICE #2  
District File Number 11-50-196  
Date Filed: NOV 25 1954

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 Karl B. Kent  
Licensed Embalmer No. 4689

P. O. Address Green 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.