

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH.

State File No. **40527**

FILED NOV 16 1951

BIRTH NO. _____ REG. DIST. NO. **373** PRIMARY REG. DIST. NO. **4545** Registrar's No. **62**

1. PLACE OF DEATH a. COUNTY WEBSTER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MARSHFIELD		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MARSHFIELD MO	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) B c. (Last) MELTON			4. DATE OF DEATH (Month) (Day) (Year) NOV 3 1951		
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH DEC 9 1868		9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR Days 10 IF UNDER 1 HR. Hours 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ROME MO	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME THOMAS MELTON		13b. MOTHER'S MAIDEN NAME Catherine	
14. NAME OF HUSBAND OR WIFE RACHEL MELTON		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.	
17. INFORMANT'S SIGNATURE OR NAME H.T. MELTON		ADDRESS MARSHFIELD			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion, Acute		II. OTHER SIGNIFICANT CONDITIONS		2 hours	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Coronary Sclerosis		Several years	
DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct., 1951, to Nov. 3, 1951, that I last saw the deceased alive on Nov. 3, 1951, and that death occurred at 10:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C.P. Macdonnell, M.D. D		23b. ADDRESS Marshfield, Mo.		23c. DATE SIGNED 11/4/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 11-7-1951		24c. NAME OF CEMETERY OR CREMATORY F.O.O.F	
24d. LOCATION (City, town, or county) (State) SPARTA MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BARBER-BARTO MARSHFIELD			
DATE REC'D BY LOCAL REG. 11-9-51		REGISTRAR'S SIGNATURE J. Francis 392			

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

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DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED NOV 10 1951
Dist. File 1151-1987
Date Filed 11-14-51

DEC 14 1951

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 Julian Jacobson

Licensed Embalmer No. 11562

P. O. Address Springfield 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.