

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

No. 300
10-48*

FILED FEB 1 1953

State File No. 2723

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 33

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

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lincoln	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Elsberry	
c. LENGTH OF STAY (In this place) 10 days		d. STREET ADDRESS (If rural, give location) /	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			

0570
/

3. NAME OF DECEASED (Type or Print) a. (First) Ray b. (Middle) Frank c. (Last) Meloon			4. DATE OF DEATH (Month) (Day) (Year) Jan. 24, 1953		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 16, 1891	9. AGE (In years last birthday) 61	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane operator -ret.
10b. KIND OF BUSINESS OR INDUSTRY Construction			11. BIRTHPLACE (City and State or Foreign Country) Paynesville, Mo.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME R. S. Meloon		13b. MOTHER'S MAIDEN NAME Mary Temple		14. NAME OF HUSBAND OR WIFE Elsie Mayes Meloon	
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 NUMBER NO. yes-unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Elsie Meloon - Elsberry, Missouri	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Coronary thrombosis			2 hrs.
		ANTECEDENT CAUSES DUE TO (b) Arteriosclerotic cardiovascular disease			5 yrs.
		DUE TO (c) Emphysema. Bronchial asthma			5 yrs.
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) (Min.)		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 1-12, 1953, to 1-24, 1953, that I last saw the deceased alive on 1-24, 1953 and that death occurred at 1:35a p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature] M.D.		23b. ADDRESS 114 N. Main St., St. Chas. Mo.		23c. DATE SIGNED Jan 30-53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE Jan. 25, 1953		24c. NAME OF CEMETERY OR CREMATORY Greenwood		24d. LOCATION (City, town, or county) (State) Clarkeville, Mo.	
DATE REC'D BY LOCAL REG. Jan 31 1953		REGISTRAR'S SIGNATURE Francis Hammett		GENERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Elsberry, Mo	

STATEMENT BY LICENSED EMBALMER

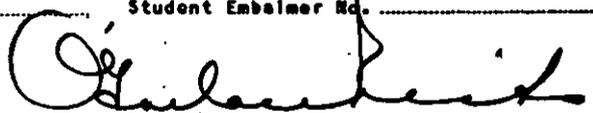
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. 4012

P. O. Address Edoberg, 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.