

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12136**  
**3073**  
Registrar's No.

FILED APR 4 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>	
b. CITY OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <b>Morehouse</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>0100</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Melissa</b> b. (Middle) <b>A.</b> c. (Last) <b>Pease</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>March 19, 1953</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>May 4, 1878</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Bond Co., Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>

13a. FATHER'S NAME <b>William Hunter</b>	13b. MOTHER'S MAIDEN NAME <b>Mary E. Scott</b>	14. NAME OF HUSBAND OR WIFE <b>Unavailable</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. A.T. Welsh, Springfield, Ill.</b>	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 <b>1 yr?</b> <b>1 yr?</b> <b>2 wks</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinomatous, wide spread, active abdomen</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>large pelvic mass - possibly undetermined</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Embolic right popliteal artery</b>			

19a. DATE OF OPERATION <b>3-20-53</b>	19b. MAJOR FINDINGS OF OPERATION <b>Carcinomatous cystic abdomen</b>	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)
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? <b>1991</b>

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **5:30p** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Jay E. Flynn M.D.</b> (Degree or title)	23b. ADDRESS <b>1645 Broadwood</b>	23c. DATE SIGNED <b>3-20-53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>3-20-53</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>Carrollton, Ill.</b>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>MAR 21 1953</b> <b>J. Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	ADDRESS <b>4700 Washington Blvd.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed *J. W. B. Embler*.....

Licensed Embalmer No. *3653*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.