

FILED JAN 28 1957

STANDARD CERTIFICATE OF DEATH

335
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 49

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Holt</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Joseph, Mo.</u>		c. CITY OR TOWN <u>Mound City, Mo.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Methodist Hosp. 5 days</u>		d. STREET ADDRESS (If outside, give location) <u>Reside on Farm</u>	

3. NAME OF DECEASED (Type or print) First <u>Olma</u> Middle <u>Virginia</u> Last <u>Melton</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1861</u>	9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>in the home</u>		11. BIRTHPLACE (City and state or country) <u>Stone Hill, Virginia</u>	
13. FATHER'S NAME <u>A. J. Kite</u>			14. MOTHER'S MAIDEN NAME <u>Clarinda Kite</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Frank Hauman</u> Address <u>Craig, Mo</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vasculor accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>hypertension, arteriosclerosis.</u>		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Fracture, Left femur.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell in her own home causing</u>			
20c. TIME OF INJURY Hour <u>no</u> Month <u>1</u> Day <u>16</u> Year <u>57</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. CITY, TOWN, OR LOCATION <u>Mound City, Holt, Mo.</u>			
21. I attended the deceased from <u>1/16/57</u> to <u>1/18/57</u> and last saw her alive on <u>1/17/57</u> Death occurred at <u>6:40 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>John Johnson, M.D.</u> (Degree or title)		22b. ADDRESS <u>420 N. 8th St. St. Joseph, Mo.</u>		22c. DATE SIGNED <u>1/18/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Jan. 20, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Liberty</u>	
23d. LOCATION (City, town, or county) <u>Holt, Mo.</u>		23e. (State) <u>Mo</u>			

24. FUNERAL DIRECTOR <u>James Crawford</u> Address <u>Mound City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 21, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	
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Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300
-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be traced. All causes in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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by funeral e

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 *James Bradford*

Licensed Embalmer No. *47*

P. O. Address *Round City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.