

Dept. Health,  
uc., & Welfare  
J. S. Public  
Health Service

FILED DEC 23 1957

STANDARD CERTIFICATE OF DEATH

45290

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 43

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sedalia</b>		c. CITY OR TOWN <b>Sedalia</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Campbell Nursing Home 1401 West Third</b>		d. STREET ADDRESS <b>406 West 7th</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>NORA</b> Middle <b>LEE</b> Last <b>MELTON</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>19</b> Year <b>1957</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 20, 1875</b>	9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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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>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Pettis County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Hedgemon Warren</b>	13b. MOTHER'S MAIDEN NAME <b>Irene Jamison</b>	14. NAME OF HUSBAND OR WIFE <b>Thomas R. Melton</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Birdie Howell, 1303 West 4th Sedalia, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis, generalized</b>	
	DUE TO (c) <b>Diabetes Mellitus</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>260X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input 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.)
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20c. TIME OF INJURY Hour <b>2:30</b> Month, Day, Year <b>12-19-57</b> a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Sedalia</b> COUNTY <b>Missouri</b> STATE <b>Missouri</b>
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21. I attended the deceased from <b>19:55</b> to <b>Dec - 57</b> and last saw her alive on <b>12-11-57</b> Death occurred at <b>12:30 AM 12-19-57</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Alvin L Lowe M.D.</b> (Degree or title)	22b. ADDRESS <b>Sedalia, Mo.</b>	22c. DATE SIGNED <b>12-20-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/20/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Sedalia, Missouri</b>
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24. FUNERAL DIRECTOR <b>Dwaine Cowing</b> ADDRESS <b>Sedalia, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-20-57</b>	26. REGISTRAR'S SIGNATURE <b>Frances A. Selby</b>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

541

JAN 2 1958

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 *P. E. Baker* .....

Licensed Embalmer No. *2419* .....  
P. O. Address *Seclusion* .....

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.