

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

598

FILED FEB 3 1958

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 2

300
-57

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1. PLACE OF DEATH a. COUNTY <u>Clay</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Excelsior Springs</u> <u>60022</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Springs Hspital</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>719 S. Marietta</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Melling</u> Last <u>Melling</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>3</u> Year <u>1958</u>		
5. SEX <u>Male</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 checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28, 1893</u>	9. AGE (In years last birthday) <u>64</u>	10. FUNDER 1 YEAR Months <u>6</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Richmond, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>John Melling</u>		13b. MOTHER'S MAIDEN NAME <u>Minnie Jane Spurbek</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes, Unk</u>		17. INFORMANT <u>719 S. Marietta Goldie Kerns, Excelsior Springs, 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>Toxemia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>June-1957</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of right lung and lymph glands with metastasis to left femur</u>					<u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>8/27/57 Spontaneous fracture of left femur</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)		
20c. TIME OF INJURY Hour <u>3:00</u> Month, Day, Year <u>8/27/57</u> a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <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 COUNTY STATE	
21. I attended the deceased from <u>8/27/57</u> to <u>1/3/58</u> and last saw <u>her</u> alive on <u>1/3/58</u> Death occurred at <u>3:00 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Dr. M. Crick</u> (Degree or title)		22b. ADDRESS <u>M.D. Excelsior Springs, Mo.</u>		22c. DATE SIGNED <u>1/10/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-5-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>	
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> ADDRESS <u>Excelsior Springs, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>1/10/58</u>		26. REGISTRAR'S SIGNATURE <u>Caroline Hitching</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.



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 *Lindell Jarman*

Licensed Embalmer No. *4589*
Embalmer Springs

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.