

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020999

STATE FILE NUMBER

FILED JUL 7 1959

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 684A

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY BRENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER	
b. CITY OR TOWN SPRINGFIELD MO Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN MARSHFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE Hosp		Length of stay in lb 1 MO	
d. STREET ADDRESS 408 MAPLE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First LORA Middle THETIS Last MELTON			4. DATE OF DEATH Month JUNE Day 22 Year 1959		
--	--	--	--	--	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 29 1892	9. AGE (in years last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
--------------------	-------------------------------	---	-------------------------------------	---	---	-----------------

10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) PET DENTIST	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A
--	-----------------------------------	--	---

13a. FATHER'S NAME JAMES MELTON	13b. MOTHER'S MAIDEN NAME RACHEL LEE	14. NAME OF HUSBAND OR WIFE
--	---	-----------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 495-40-6470	17. INFORMANT Address GEORGE MELTON MARSHFIELD MO
---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction due to arteriosclerotic coronary thrombosis 4 wks		INTERVAL BETWEEN ONSET AND DEATH 4 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
---	--

20c. TIME OF INJURY Hour 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 June 1, 59 to June 22, 59 and last saw ^{her} him alive on June 21, 59 Death occurred at 325 A m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) E. Callaway MD	22b. ADDRESS Springfield, Mo	22c. DATE SIGNED 6/29/59
--	-------------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 6-22-1959	23c. NAME OF CEMETERY OR CREMATORY MARSHFIELD	23d. LOCATION (City, town, or county) (State) MARSHFIELD MO
--	----------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS BA RBER-EDWARDS MARSHFIELD, MO	25. DATE RECD. BY LOCAL REG. 6-29-59	26. REGISTRAR'S SIGNATURE Effie G. Melton
--	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *R. W. Barber*

Licensed Embalmer No. *387*

P. O. Address *Mt. Grove Pa*

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.