

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-024981
STATE FILE NUMBER

Registration District No. 143 Primary Registration District No. 4232 Registrar's No. 42

AMENDED

FILED AUG 3 1961

1. PLACE OF DEATH a. COUNTY Howell		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Howell	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Willow Springs		Length of stay in 1b 7 Days	c. CITY OR TOWN Willow Springs Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) E. 2nd Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Infant - George H. MELTON			4. DATE OF DEATH Month Day Year July 23, 1961		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/12/61	9. AGE (last birthday) -	IF UNDER 1 YEAR Months Days Hours Min. - 11 - - -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Mtn. View, Mo.	11. BIRTHPLACE (City and state or country) USA		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Elmer F. Melton		13b. MOTHER'S MAIDEN NAME Lodema Casey		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. None	17. INFORMANT E. F. Melton, Willow Springs, Mo. Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Pneumonia bronchial		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) gastric regurgitation	
DUE TO (c) Cerebral Trauma		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Infancy of 11 days		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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. Month, Day, Year		

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 Willow Springs, Mo.	COUNTY Howell	STATE Mo.
21. I attended the deceased from 7/12/61 to 7-22-61 and last saw him alive on 7-22-61 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE Harold W. Miller Harold W. Miller, M.D.	22b. ADDRESS Willow Springs, Mo.	22c. DATE SIGNED 7/23/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/23/61	23c. NAME OF CEMETERY OR CREMATORY Montier	23d. LOCATION (City, town, or county) Montier, Mo.
24. FUNERAL DIRECTOR Burns, Willow Springs, Mo.		25. DATE RECD. BY LOCAL REG. 7/31/61	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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

" NO EMBALMING "

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.