

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

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1. PLACE OF DEATH

County Douglas
Township Buffalo
City Cardwell (No.)

Registration District No. 283
Primary Registration District No. 540C

File No.
Registered No.
St. Ward

2. FULL NAME

(a) Residence, No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 3 1919

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>16</u>	<u>2</u>	<u>3</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER FATHER 13. NAME Isaac Shaffeld

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Butler

15. MAIDEN NAME Lydia Williams

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Donnott Mo.

17. INFORMANT Lydia Hatcher (ADDRESS) Donnott Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Donnott Mo. DATE Dec. 10 1935

19. UNDERTAKER Pitchell Anderson (ADDRESS) Donnott Mo.

20. FILED 1-15 1936 P. H. Moore Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-9 1935

22. I HEREBY CERTIFY, That I attended deceased from 12-8 1935 to 12-9 1935

I last saw h. or alive on 12-8 1935 Death is said to have occurred on the date stated above, at 7 AM.

The principal cause of death and related causes of importance were as follows:

Intestinal Obstruction Date of onset

Other contributory causes of importance: Pneumonia lobar

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external cause (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify Wallach English, M. D.

(Signed) Wallach English, M. D.

(Address) Cardwell, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Dunklin
Township _____
City _____

Registration District No. 283
Primary Registration District No. 5402

File No. _____
Registered No. _____ St. _____ Ward)

2. FULL NAME

Rosie Melkeld

(a) Residence, No. _____ St. _____ Ward. _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
16 2 3

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS)

20. FILED 1-15-36 W. W. Mowson Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/9 1935

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Intestinal obstruction Date of onset
acute ileus
Further information
Other contributory causes of importance:
pneumonia, lobar

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Wallace D. English M. D.
(Address) Cardwell, Mo

SUPPLEMENTARY

5-39124

RECEIVED
MAY 19 1964