

SEP 20 1939

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

29041
Do not use this space.

1. PLACE OF DEATH
 (a) County Douglas Registration District No. 284
 (b) Township Highburn Primary Registration District No. 4108 Registered No. 12
 (c) City Clairton Street No. _____ St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME Melvin Denson (DENSON)
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Single
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 14 1927
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
12
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
 9. Industry or business in which work was done, as saw mill, bank, etc. none
 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) St. Mary Co. Missouri
 FATHER
 13. NAME Joe M. Denson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brantley Co. Georgia
 MOTHER
 15. MAIDEN NAME Ollee Barber
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jay Co. Ark
 17. INFORMANT (ADDRESS) Joe M. Denson
 18. BURIAL, CREMATION, OR REMOVAL PLACE Stangeled DATE Aug 17 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Shelby Rural
 20. FILED 8/17 1939 J. B. Stimmig Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 16 1939
 22. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1939 to Aug 16, 1939
 I last saw him alive on Aug 10, 1939 Death is said to have occurred on the date stated above, at 9:40 m.
 The principal cause of death and related causes of importance were as follows:
Asphyxia
 Date of onset _____
 Other contributory causes of importance: _____
 Name of operation none Date of _____
 Post test confirmed diagnosis Choked Was there an autopsy? no
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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 none
 Nature of injury none
 24. Was disease or injury in any way related to occupation of deceased? no
 specify _____
 (Signed) Joe M. Denson, M. D.
 25. (Address) Stangeled

(Licensed Embalmer's Statement on Reverse Side)

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.

WHILE FILLING IN THIS IS A PERMANENT RECORD I X16603

RECEIVED

District Health Officer No. 3,

District File Number 939-543

Date filed 9/6/39

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.....

....., Registered Apprentice No.....

working under my personal supervision.

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 this body is not embalmed, above space should be left blank.