FILED MAR 11 1940

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

7929
Do not use this space.

1. PLACE OF DEATH
(a) County Ripley 0 Registration District No. 751
(b) Township Warner Primary Registration District No. 5992 Registered No. 1426
or
(c) City Rural (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 345 Ada Francis Medling
(a) Residence, No. same St. ☐
(Usual place of abode, if no street address, write county or city) (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): married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Wm Medling
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): July 7, 1875
7. AGE: YEARS 64 MONTHS 6 DAYS 2 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife
9. Industry or business in which work was done, as 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): Franklin Co. Ill. 1

FATHER
13. NAME: William Lance 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Franklin Co. Ill. 9

MOTHER
15. MAIDEN NAME: Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Clarence Medling Oxly Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Arnold Cem DATE 1-11, 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Minnie Gish Naylor Mo.
20. FILED 1/10, 1940 H Eemhett Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-9-, 1940
22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1940, to Jan 9, 1940
I last saw her alive on Jan 9, 1940. Death is said to have occurred on the date stated above, at 1:15 P.m.
The principal cause of death and related causes of importance were as follows:
Labor pneumonia
Date of onset
Other contributory causes of importance: pleuronary tuberculosis
Name of operation none Date of
What test confirmed diagnosis? Unused Was there an autopsy? no
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? no
If so, specify
(Signed) H Eemhett M. D.
(Address) Naylor Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

11

1 X16605

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.

RECEIVED

District Health Officer No. 5,

District File Number 340 266

Date Filed 3 8 40

Signed S. C. McCord

Licensed Embalmer No. 4979

P. O. Address Naylor, Mo.

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.

. No. 2B
—2-21-40
I X 2659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7920

Registration District No. 751 Primary Registration District No. 5992 Registrar's No.

1. PLACE OF DEATH:

(a) County Ripley

(b) ~~City or town~~ Varner Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ripley

(c) City or town rural — Varner township
(If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ada Francis Medling

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 64 Months 6 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) Apr 15 - 40 (Date received local registrar) (b) H. E. White M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 9 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature H. E. White (M. D. or other)
Address Naylor Mo Date signed

SUPPLEMENTARY