

Registration District No. 1

Primary Registration District No. 1

Registrar's No. 246

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town arksville  
(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 Life time years, months or days

3. (a) PRINT FULL NAME MOLLIE SUSAN MADISON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Don't know  
(Month) (Day) (Year)

8. AGE: Years 74 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation House Keeper

11. Industry or business \_\_\_\_\_

12. Name Step madison

13. Birthplace arksville mo (City, town, or county) (State or foreign country)

14. Maiden name Ann Jones

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

16. (a) Informant Robert Williams

(b) Address arksville mo

17. (a) Burial (b) Date thereof Aug 19/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest

18. (a) Signature of funeral director Summer Shuck  
(b) Address arksville mo

19. (a) Aug 25/41 (b) Spencer L. Freeman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Adair  
(c) City or town arksville  
(If outside city or town limits, write "RURAL")  
(d) Street No. High (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Aug 13 1941  
19 \_\_\_\_\_ to Aug 13 1941  
that I last saw her alive on Aug 13 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy Duration \_\_\_\_\_

Due to Myocardial Degeneration

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 \_\_\_\_\_

Signature Dr. L. H. Drey (M. D. or other) \_\_\_\_\_  
Address Stephenson Hotel Date signed Aug 22 1941

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

2  
41  
19

6390

RECEIVED

District Health Officer No. 10

District File Number 7-41-1659

Date Filed SEP 16 1941

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 W. C. Summers

Licensed Embalmer No. 2159

P. O. Address Riverview

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**