V. S. No. 2
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Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 7 1944

Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31779

Primary Registration District No. 6076

Registrar's No. 2005

1. PLACE OF DEATH:

(a) County St. Louis County

(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Facility 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Adm. Sept. 22, 1944 (Specify whether
In this community One year.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County 999

(c) City or town EAST ST. LOUIS 11
(If outside city or town limits, write "RURAL")

(d) Street No. 134 St. Clair Street 11
(If rural, give location)

(e) Citizen of foreign country? - (Yes or No)

If yes, name country - 2

3. (a) PRINT FULL NAME MEDLOCK, Herbert R.

3. (b) If veteran, name war World War #1

3. (c) Social Security No. Yes-not remembered.

4. Sex 0 Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower 2

6. (b) Name of husband or wife -

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

7. Birth date of deceased April (Month) 12, (Day) 1897 (Year)

8. AGE: Years 47 Months 5 Days 17 If less than one day ___ hr. ___ min.

9. Birthplace Macon (City, town, or county) Georgia (State or foreign country) 1

10. Usual occupation Laborer

11. Industry or business -

FATHER
12. Name John G. Medlock
13. Birthplace Lewisville (City, town, or county) Georgia (State or foreign country) 1

MOTHER
14. Maiden name Clare Roberson
15. Birthplace Lewisville (City, town, or county) Georgia (State or foreign country) 1

16. (a) Informant M. Schillig
(b) Address Clinical Clerk, VAF, Jeff. Bks., Mo.

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof Sept. 30 - 44 (Month) (Day) (Year)

(c) Place: burial or cremation ATLANTA, GEORGIA

18. (a) Signature of funeral director C. Hoffmeister U. & Co.
(b) Address 7814 S. Broadway

19. (a) OCT 2 1944 (Date received local registrar) (b) E. S. McGavran, M.D. (Registrar's signature) Cms

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 29th, year 1944 hour 5:20 minute A. M.

21. I hereby certify that I attended the deceased from Sept. 22, 1944 to Sept. 29, 1944; that I last saw him alive on Sept. 29, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death PARALYTIC ILEUS.	Unknown
Due to LOBAR PNEUMONIA, RIGHT, TYPE UNDETERMINED, WITH PLEURISY.	Abt. 9-days.
Due to -	
Other conditions CIRRHOSIS OF LIVER. (Include pregnancy within 3 months of death)	Unknown

108

Major findings:
Of operations Thoracentesis 9/23/44, right pleural cavity.
Of autopsy No 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) no

(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 W. A. GERMAN, M. D., (M. D. or other)

Address Chief Medical Officer. Date signed 9/29/44

(Licensed Embalmer's Statement on Reverse Side)

OCT 19 1944

FEB 1 1945

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 Harry J. Schumacher

Licensed Embalmer No. 2679

P. O. Address 732 Lemay Ferry Rd.

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, fact should be so stated above.