

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

**1. PLACE OF DEATH:**  
 (a) County Dunklin  
 (b) City or town Malden  
 (c) Name of hospital or institution: Barstow Clinic  
 (d) Length of stay: In hospital or institution 1 week  
 In this community \_\_\_\_\_  
 years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State \_\_\_\_\_, (b) County 35  
 (c) City or town \_\_\_\_\_  
 (d) Street No. \_\_\_\_\_  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME:** Lela Ester Sandlin  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Dec day 22  
 year 1944 hour 2 minutes 55 P. M.

4. Sex F. 5. Color of hair H.  
 6. (a) Single, widowed, married, divorced (1)  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

**21. I hereby certify that I attended the deceased from**  
Dec 18, 1944 to Dec 22, 1944  
 that I last saw her alive on Dec 22, 1944  
 and that death occurred on the date and hour stated above.

**7. Birth date of deceased:** July 24 1944  
 (Month) (Day) (Year)  
**8. AGE:** Years \_\_\_\_\_ Months 4 Days 28  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Locked Bowell  
 Duration Dec 18/44

**9. Birthplace:** Brosley mo  
 (City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

**10. Usual occupation:** \_\_\_\_\_  
**11. Industry or business:** \_\_\_\_\_  
**12. Name:** Hadden F. Sandlin  
**13. Birthplace:** Malden mo  
**14. Maiden name:** Lela Ester Lawrence  
**15. Birthplace:** Malden mo

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**16. (a) Informant:** Lela Sandlin  
 (b) Address: Caton mo  
**17. (a) Burial:** \_\_\_\_\_ (b) Date thereof: 12-23-44  
 (c) Place: burial or cremation: Mourning Cam.  
**18. (a) Signature of funeral director:** none  
 (b) Address \_\_\_\_\_  
**19. (a) Jan 5 45** (b) H. Elder  
 (Date received local registrar) (Registrar's signature)

**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? \_\_\_\_\_  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work? \_\_\_\_\_ (Specify type of place)  
**23. Signature:** Dr. Catton (M. D. or other)  
 Address: Malden Date signed: Dec 24/44

RECEIVED

District Health Office No. 2

District File Number 245-149

Date Filed 2-7-45

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**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, fact should be so stated above.**