

**FILED JUN 12 1945**

Registration District No. 341

Primary Registration District No. 3075

Registrar's No. 16

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Dexter

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: - In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 66 year \_\_\_\_\_ (Specify whether)

years, months or days

3. (a) PRINT FULL NAME Olive Medlin

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Wm. B. Medlin 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Dec 29th 1870

(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>3</u>	<u>14</u>	hr. _____ min.

9. Birthplace Fairfield Illinois

(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Don't Know

13. Birthplace Don't Know 9

(City, town, or county) (State or foreign country)

14. Maiden name Mary Herron

15. Birthplace Don't Know 9

(City, town, or county) (State or foreign country)

16. (a) Informant W. B. Medlin

(b) Address Dexter, Mo.

17. (a) Burial (b) Date thereof 4/13/45

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Smith-Stephenson Cem.

18. (a) Signature of funeral director Watkins Funeral Ser

(b) Address Dexter, Mo

19. (a) 6-1-45 (b) Noea Smith

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard 103

(c) City or town Dexter Mo.

(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.? No. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19th year 1945 hour 4 minute 30 M.

21. I hereby certify that I attended the deceased from April 9th 1945 to April 10th 1945 that I last saw her alive on April 9th 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Colon at Ceco Sigmoid

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: no

Of operations no

Of autopsy no

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?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature S. S. [unclear] (M. D. or other) \_\_\_\_\_

Address Dexter Mo Date signed 4-14-45

RECEIVED

District Health Office No.

District File Number 645-811

Date Filed 6-6-45

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.