

S. No. 2
M-5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16328**
Registrar's No. **380**

Registration District No. **128** Primary Registration District No. **2000**

1. PLACE OF DEATH:
(a) County **GREENE**
(b) City or town **SPRINGFIELD, MO.**
(c) Name of hospital or institution: **ST. JOHN'S HOSPITAL 0**
(d) Length of stay: In hospital or institution **2 WEEKS**
In this community **70 YEARS**

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **WRIGHT/14**
(c) City or town **Mt. Grove, Mo. 1**
(d) Street No. **0**
(e) Citizen of foreign country? **1** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **CALVIN ADAM MEDLOCK**
3. (b) If veteran, name war **UNK. ✓** 3. (c) Social Security No. **UNK.**
4. Sex **MALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **SARAH TITTLE**
6. (c) Age of husband or wife if alive **70** years
7. Birth date of deceased **JULY 5 1970**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **MAY** day **3** year **1946** hour **6** minute **45**
21. I hereby certify that I attended the deceased from **4-20**, 19**46**, to **5-3**, 19**46**
that I last saw h. **1m** alive on **5-2**, 19**46**, and that death occurred on the date and hour stated above.

8. AGE: Years **75** Months **09** Days **28** If less than one day hr. min.

Immediate cause of death **Arterio Sclerosis**
Due to _____
Due to _____

9. Birthplace **DENT. MO. 0**
10. Usual occupation **FARMER**

Other conditions **Ca of Prostate**
Major findings: Of operations _____
Of autopsy **5/11**

MOTHER FATHER
11. Industry of business _____
12. Name **WILLAS MEDLOCK**
13. Birthplace **Unknown unk. 9**
14. Maiden name **(UNK.) Summers**
15. Birthplace **Unknown unk. 09**
16. (a) Informant **Mrs. Edith Springer**
(b) Address **Springfield, Mo.**
17. (a) **Burial** (b) Date thereof **MAY 5 46**
(c) Place: burial or cremation **Hillcrest**
18. (a) Signature of funeral director **R. W. Barber**
(b) Address **Mt. Grove Mo.**
19. (a) **5-4-46** (b) **S. W. 2 Handley**

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) (e) Means of injury **0**
23. Signature **Medlock** (M. D. or other) **MD.**
Address **Springfield, Mo.** Date signed **5-4-46**

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

1946

100

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..... *R. W. Barber*.....
Licensed Embalmer No..... *3848*.....
P. O. Address..... *Int'l. Home, 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, fact should be so stated above.

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