

Health, Welfare, Public Service
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 300
 5-56
 ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms will be listed. All

FILED JAN 21 1957

STANDARD CERTIFICATE OF DEATH

130
 STATE FILE NUMBER

Registration District No. 13 Primary Registration District No. 3003 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>Barry</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Barry</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Monett</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Monett</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Vincent Hosp.</u>		Length of stay in 1b <u>69 Yrs</u>	d. STREET ADDRESS (If outside, give location) <u>525 Cleveland Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MABLE</u> Middle <u>MEDLIN</u> Last <u>MEDLIN</u>			4. DATE OF DEATH <u>Jan 6, 1957</u> Month <u>Jan</u> Day <u>6</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 21, 1887</u>	9. AGE (In years last birthday) <u>69</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>6</u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Barry County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>B. C. COMBS</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Clark Millikan Monett, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>332x</u>					INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u> <u>8 1/2</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>3</u>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>6/10/46</u> to <u>1/6/57</u> and last saw her/him alive on <u>1/6/57</u> Death occurred at <u>8:30</u> <u>P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Frank R. Ken MD</u>			22b. ADDRESS <u>Monett Mo</u>		22c. DATE SIGNED <u>1/19/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 8, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Waldensian</u>		23d. LOCATION (City, town, or county) (State) <u>Barry County, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>J. D. BUCHANAN MONETT, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>1-12-57</u>		25. REGISTRAR'S SIGNATURE <u>Mrs O. N. Cook</u>	

BARRY COUNTY HEALTH UNIT
CASSVILLE, MO.

NO. 157-5

DATE REC. 1-14-57

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, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. D. Buchanan*

Licensed Embalmer No. 3179

P. O. Address Monett,

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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