

Registration District No. 318

Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(c) Name of hospital or institution 850 S. Filadelfia 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 months 1/2  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME SADIE A. DEDMON 355

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race wh  
6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife Wm Dedmon  
6. (c) Age of husband or wife if alive ✓ years  
7. Birth date of deceased Feb 14 1875  
(Month) (Day) (Year)

8. AGE: Years 76 Months 11 Days 26  
If less than one day hr. min.

9. Birthplace Mansfield Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation home

11. Industry or business

12. Name Robert Newton

13. Birthplace Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Malessie Ellen Newton

15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature W. W. Regues

(b) Address Springfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-40  
(Month) (Day) (Year)

(c) Place: burial or cremation Newton Cem. Mansfield

18. (a) Signature of funeral director Kelley Herrell

(b) Address Seaman Mo.

19. (a) 2-12-40 (b) Chas A. George  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wright  
(c) City or town Mansfield Mo. Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ✓ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 10  
year 1940 hour 8:45 minute P M.

21. I hereby certify that I attended the deceased from 12-19-39 to 2-10-40, 1940  
that I last saw her alive on 2-7, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Hepatitis with  
ulcers of liver  
Due to unknown

Due to inanition

Other conditions ✓  
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy ✓

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? ✓  
(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) (a) Means of injury ✓

23. Signature W. S. Walsh (M. D. or other)  
Address Springfield Mo Date signed 2/13/40

Duration unknown  
Physician W. S. Walsh  
Underline the cause to which death should be charged statistically

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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, above space should be left blank.**

X