

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

39601
Do not use this space.

1. PLACE OF DEATH **DEC 25 1939**
 (a) County **GREENE** / Registration District No. **318**
 (b) Township **SPRINGFIELD** / Primary Registration District No. **2001** Registered No. **820**
 (c) City **SPRINGFIELD** (d) Street No. **Springfield Baptist Hospital** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **LETA DIABEL ANDEYSON**
 (a) Residence, No. **Mountain Cross Mo.** St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) **Marion L. Culman**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **1-14-1891**

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
✓ 48	9	29	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) **Spanville Ark** (STATE OR COUNTRY) **Ark**

FATHER
 13. NAME **Thomas Thorne**
 14. BIRTHPLACE (CITY OR TOWN) **Lenna** (STATE OR COUNTRY) **Ind**

MOTHER
 15. MAIDEN NAME **Anna P. Larkin**
 16. BIRTHPLACE (CITY OR TOWN) **Ind** (STATE OR COUNTRY) **Ind**

17. INFORMANT (NAME) **Marion L. Culman** (ADDRESS) **Mt. Cross Mo**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Hill Crest Bur.** DATE **11-13** 19**39**

19. FUNERAL DIRECTOR (NAME) **George Staff** (ADDRESS) **Mt. Cross Mo**

20. FILED **Nov 13** 19**39** **Chas W George** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **11-11** 19**39**

22. I HEREBY CERTIFY, That I attended deceased from **10-10** 19**39**, to **11-11** 19**39**. I last saw **or** alive on **11-11** 19**39**. Death is said to have occurred on the date stated above, at **2 P.** m. The principal cause of death and related causes, of importance were as follows:
General Peritonitis
Ruptured Abdominal Aneurysm
 Date of onset

Other contributory causes of importance: **1176**

Name of operation **none** Date of
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) **Walter Smith** M. D.
 (Address) **Springfield Mo**

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.

STATEMENT BY LICENSED EMBALMER

X 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.....

George Stapp
Licensed Embalmer No. *3161*

P. O. Address *11th Lane MD*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.