

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.

Registration District No. 318

Primary Registration District No. 9.006

Registrar's No. 857

1. PLACE OF DEATH:

(a) County Greene  
 (b) City or town \_\_\_\_\_  
 (c) Name of hospital or institution: St. Johns Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 2 days  
 years, months or days

3. (a) PRINT FULL NAME ALBERT MARION LETT 3A71

3. (b) If veteran, 4 years in Navy name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White  
 6. (b) Name of husband or wife Flora Lett  
 6. (c) Age of husband or wife If alive 55 years  
 7. Birth date of deceased February 17 1884  
 (Month) (Day) (Year)

8. AGE: Years 55 Months 9 Days 8  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Carroll County Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

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

12. Name Matthew H. Lett  
 13. Birthplace No Record  
 (City, town, or county) (State or foreign country)

14. Maiden name Anna Wicker  
 15. Birthplace No Record  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Flora Lett

(b) Address Rt 1, Cape Fair, Missouri

17. (a) Burial (b) Date thereof Nov. 27 1939  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director H. C. Whisner

(b) Address Springfield, Mo.

19. (a) 11-27-39 (b) Charles George M. S.  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
 (c) City or town Springfield  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Road #1 Cape Fair, Mo.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 25  
 year 1939 hour 1 minute 55 A.M.

21. I hereby certify that I attended the deceased from 11/14/39  
 \_\_\_\_\_, 19\_\_\_\_, to 11/25 1939  
 that I last saw him alive on 11/25/39  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer 2nd grade, carcinoma of sigmoid flexure  
 Due to double  
 Due to Uremia

Other conditions Bladder & 70 ml  
 (Include pregnancy within 3 months of death)  
see 18c

Major findings: Of operations Biopsy 11/14/39 Ca

Of autopsy Yes  
Dr. M. H. Stone

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. J. Wills (M. D. or other) \_\_\_\_\_  
 Address Ballou St. - Springfield Date signed 11/26/39

PHYSICIAN

Underline the cause to which death is attributed. (M. D. or other) \_\_\_\_\_  
 (Signature) \_\_\_\_\_  
 (Address) \_\_\_\_\_

578

---

**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.....

*Self*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Ralph Thieme*.....

Licensed Embalmer No. *3681*.....

P. O. Address *Springfield, 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, above space should be left blank.**

*X*

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

39635

Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318  
 (b) Township Springfield Primary Registration District No. 2001 Registered No. 857  
 (c) City Springfield (d) Street No. \_\_\_\_\_  
 (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

Albert Marion Lett  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 25 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

The principal cause of death and related causes of importance were as follows:  
Cancer of 2d grade carcinoma primary seat bladder (trigone) Greene

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
55 9 8

Date of onset \_\_\_\_\_

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 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 \_\_\_\_\_

Other contributory causes of importance: 51

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_ 14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_ 16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED 1-15-40 Chas. O. George MD Local Registrar

Name of operation \_\_\_\_\_ 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 \_\_\_\_\_ 19\_\_\_\_  
 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) Wm. J. Willis M. D.  
 (Address) Springfield Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

