

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

15828
 Do not use this space.

1. PLACE OF DEATH

(a) County Polk Registration District No. 702
 (b) Township..... Primary Registration District No. 4423 Registered No.....
 (c) City Fairplay (d) Street No..... 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 William T Fleeman

(a) Residence, No. 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rebecca F
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 25, 1860
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 80 80 1 21
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. agriculture
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 15th, 1940
 22. I HEREBY CERTIFY, That I attended deceased from Apr 8 1940, 19... to Apr 15 1940, 19...
 I last saw him alive on Apr 15 1940, 19... Death is said to have occurred on the date stated above, at 2.30 PM
 The principal cause of death and related causes of importance were as follows:
Mitral stenosis, chronic Date of onset 8 yrs
Chronic prostritis and acute urinary retention 6 Mo.
Arterio sclerosis 7 day

Other contributory causes of importance:
None

Name of operation..... None Date of.....
 What test confirmed diagnosis? Clinical Was there an autopsy?..... No

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? No
 If so, specify.....
 (Signed) Chas H Brown, M. D.

12. BIRTHPLACE (CITY OR TOWN) Fairplay C
 (STATE OR COUNTRY) Missouri

FATHER 13. NAME George C Fleeman 1
 14. BIRTHPLACE (CITY OR TOWN) Virginia 1
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Mary Price
 16. BIRTHPLACE (CITY OR TOWN) Indiana
 (STATE OR COUNTRY)

17. INFORMANT Rebecca Fleeman
 (ADDRESS) Fairplay Missouri

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Bethel DATE April 17, 1940

19. FUNERAL DIRECTOR (NAME) Hutcheson and Co
 (ADDRESS) Bolivar Missouri

20. FILED apr 20 40 L R Hunt 631 (Address) Fair Play Mo
 Local Registrar.

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.

RECEIVED
District Health Officer No. 7,
District File Number 5-40-797
Date Filed 5-7-40

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

S. B. Hutchinson, Registered Apprentice No. 1331
working under my personal supervision.

Signed S. B. Hutchinson
Licensed Embalmer No. 1331
P. O. Address U.S. Army

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.