

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41992

State File No. \_\_\_\_\_

Registration District No. 96

Primary Registration District No. 4058

Registrar's No. 43

**1. PLACE OF DEATH:**  
 (a) County Caldwell  
 (b) City or town Hamilton  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location) 2  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

**3. (a) PRINT FULL NAME** Lettie Tyie  
 8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widow  
 6. (b) Name of husband or wife deceased 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Nov. 28 1892  
 (Month) (Day) (Year)

**8. AGE:** Years 68 Months 0 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** Guilford Missouri  
 (City, town, or county) (State or foreign country)

**10. Usual occupation** House wife

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

**MOTHER FATHER**  
 { **12. Name** Robert Nelson  
 { **13. Birthplace** Denmark  
 { **14. Maiden name** Maria Nelson  
 { **15. Birthplace** Denmark

**16. (a) Informant** L. G. Chiles  
 (b) Address Hamilton Mo

**17. (a)** burial (b) Date thereof Dec 17 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Cemetery

**18. (a) Signature of funeral director** G. R. Spanghton  
 (b) Address Hamilton

**19. (a)** Dec 17 1940 (b) Marle Brown  
 (Inter-received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Caldwell  
 (c) City or town Hamilton  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month December day 15<sup>th</sup>  
 year 1940 hour 3 minute 30 A. M.  
**21. I hereby certify that I attended the deceased from** Sept 1  
1940 to December 15 1940  
 that I last saw her alive on December 14 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Cerebral thrombosis</u>	<u>3 mo</u>
Due to <u>arterio sclerosis</u>	<u>2</u>
Due to _____	_____
Other conditions <u>Toxic Eczema</u> (Include pregnancy within 3 months of death)	_____
<b>PHYSICIAN</b>	_____
Major findings: _____	_____
Of operations _____	_____
Of autopsy <u>none</u>	_____

Underline the cause to which death should be charged statistically.

**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?  
100 (Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
**23. Signature** Herbert R. Booth (M. D. or other) MD  
 Address Hamilton Mo Date signed 12/17/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

13  
4  
0

**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.**