

FILED DEC 17 1943  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13321

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

Registration District No. 2885

Primary Registration District No. 4316

Registrar's No. 14

1. PLACE OF DEATH:  
(a) County Macon  
(b) City or town New Cambria  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
16th Street + 11th South of Depot  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 71 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Macon 61  
(c) City or town New Cambria 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ARTHUR FLETCHER  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 19 year 1943 hour 11 minute P.M.

4. Sex Male 5. Color or Race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Lois E. Fletcher 6. (c) Age of husband or wife if alive 71 years  
7. Birth date of deceased February 10 1868  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 5 1943 to Nov 19 1943  
that I last saw him alive on Nov 19 1943 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>9</u>	<u>9</u>	____ hr. ____ min.

Immediate cause of death Arteriosclerotic 170  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Bucks County Penna  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer

Other conditions Paralytic Prostate 6 mm  
(Include pregnancy within 3 months of death)  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Jamie Fletcher  
13. Birthplace England 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Palin  
15. Birthplace England 4  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations none 977  
Of autopsy no

16. (a) Informant Mrs Lois E. Fletcher  
(b) Address New Cambria, Mo.  
17. (a) Burial (b) Date thereof Nov 21 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation New Cambria Cemetery  
18. (a) Signature of funeral director H. P. Killeland  
(b) Address \_\_\_\_\_  
19. (a) Nov 20 1943 (b) Almona M. Killeland  
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury \_\_\_\_\_  
23. Signature C. West (M. D. or other) Nov 20 1943  
Address New Cambria Mo Date signed 20-1943

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

RECEIVED

District Health Officer No. 10

District File Number 12-42-2031

Date Filed DEC 15 1943

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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.....

H. J. Gilleland....., Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed.....H. J. Gilleland.....

Licensed Embalmer No. 4019.....

P. O. Address New Canaan, 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, fact should be so stated above.