

17-39  
X38671

FILED FEB 7 1946  
Registration District No. 375 Primary Registration District No. 6281 Registrar's No. \_\_\_\_\_ State File No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Wright  
(b) City or town Mountain Grove  
(c) Name of hospital or institution: None Dan Burton  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 60 years (Specify whether years, months or days)

USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright  
(c) City or town Mountain Grove (Rural)  
(If outside city or town limits, write "RURAL")  
(d) Street No. No  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country No

3. (a) PRINT FULL NAME

Alice Fletcher

3. (b) If veteran, name war No

3. (c) Social Security No. No

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

8. AGE: Years Months Days If less than one day  
78 10 17 hr. min.

9. Birthplace Alabama (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER

12. Name Un Known  
13. Birthplace " (City, town, or county) (State or foreign country)  
14. Maiden name Un Known  
15. Birthplace " (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Hattie Fry  
(b) Address Green Mountain Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 1, 1946 (Month) (Day) (Year)  
(c) Place: burial or cremation Montgomery Cemetery

18. (a) Signature of funeral director RUSSELL BARBAR  
(b) Address Mountain Grove, Mo.

19. (a) 7-18-46 (Date received local registrar) (b) E. B. Hanner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 31<sup>st</sup>  
year 1945 hour 1:30 minute PM

21. I hereby certify that I attended the deceased from Dec. 23, 1945 to Dec. 30, 1945  
that I last saw her alive on Dec. 30, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 9 days

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations mg  
Of autopsy \_\_\_\_\_  
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?

(Specify type of place) While at work? (e) Means of injury \_\_\_\_\_

23. Signature J. B. Bridgman (M. D. coroner)  
Address Imance, Mo. Date signed 1-3-46

346

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

**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 *J. P. M. Barber*.....

Licensed Embalmer No. *3848*.....

P. O. Address *Mt. Home, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4426  
Ref.  
State File No. \_\_\_\_\_  
Registrar's No. 33

Registration District No. 375 Primary Registration District No. 62856281

1. PLACE OF DEATH:  
(a) County Wright  
(b) City or town ~~Wright~~ "Rural"  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Van Buren  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 60 yrs - (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Wright  
(c) City or town Mountain Grove  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Mrs. Addie Fry

(b) Address Green Mountain, Mo

17. (a) \_\_\_\_\_ (b) Date thereof 1-1-46 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Zion Cemetery

18. (a) Signature of funeral director: Russell Barber

(b) Address: Mt. Grove, Mo

19. (a) 7-18-46 (b) E. B. Stainer (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death: \_\_\_\_\_

Duration

Due to \_\_\_\_\_ 9 days

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (2) Means of injury \_\_\_\_\_

23. Signature: J. J. Bridges (M. D. or other)

Address: \_\_\_\_\_, Mo. Date signed: 1-3-46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
100946

SUPPLEMENTARY

4426