S. No. 2
I—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 20 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37754

Registration District No. .....

Primary Registration District No. 2000

Registrar's No. 950

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Johns Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")

(d) Street No. 1431 West Thoman 6
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Delores Ann Letterman

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased January (Month) 26, (Day) 1947 (Year)

8. AGE: Years 0 | Months 9 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Springfield (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Infant

11. Industry or business At Home

FATHER
12. Name Paul Letterman
13. Birthplace Springfield (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Pauline Agee,
15. Birthplace Springfield (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Paul Letterman,
(b) Address 1431 W. Thoman Spg. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director J.W. Klingner & Co.
(b) Address Springfield Mo.

19. (a) 11-3-47 (Date received local registrar) (b) N. L. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 3 year 1947 hour 2 minute 00 A. M.

21. I hereby certify that I attended the deceased from Nov 2 1947 to Nov. 3 1947; that I last saw her alive on Nov. 2 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: acute enteritis c̄ toxemia & convulsions	24 hrs.
Due to: Terminal rupture of lung	
Due to: Terminal intussusception	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy as above	

PHYSICIAN

Underline the cause of 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 0

23. Signature E. J. Schwartz (M. D. or other)

Address [illegible] Date signed 11-3-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Ogle Stone Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield

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.