

FILED FEB 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

153

BIRTH NO. _____		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>36</u>			
1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Columbia</u>		c. LENGTH OF STAY (in this place) <u>6 yr</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Columbia</u>		10			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone Co. Hospit</u>				d. STREET ADDRESS (If rural, give location) <u>400 Mathew St</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Louis</u> b. (Middle) <u>Marie</u> c. (Last) <u>Fletcher</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 28 1949</u>						
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>	8. DATE OF BIRTH <u>June 13 1920</u>		9. AGE (In years last birthday) <u>28</u>	10 UNDER 1 YEAR Months <u>7</u> Days <u>16</u>	11 UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Omaha Neb</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Bruce Thurber</u>		13b. MOTHER'S MAIDEN NAME <u>Gertrude Oma</u>		14. NAME OF HUSBAND GRANDFATHER <u>Oscar Hale Fletcher</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>498-24-5527</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>O.H. Fletcher Columbia Mo</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic glomerulonephritis</u>				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>toxemia of pregnancy on two occasions 2 & 4 years preceding death</u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Uremia-terminal 1/2</u>									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>64</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>D</u>					
22. I hereby certify that I attended the deceased from <u>Aug 6 1947</u> , to <u>Jan 28 1949</u> that I last saw the deceased alive on <u>Jan 27 1949</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>James Dr. Allen M.D.</u>				23b. ADDRESS <u>Columbia, Mo.</u>		23c. DATE SIGNED <u>1-28-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 30 49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Grant City Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Grant City Mo</u>				
DATE REC'D BY LOCAL REG. <u>Jan 29 1949</u>		REGISTRAR'S SIGNATURE <u>Mrs R E Palmer 31</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>A. D. Willard</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

Date Filed JAN 31 1949
DEPARTMENT OF HEALTH
OFFICE NO. 9

APR 6 1951

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Lynna W. Sprinkle

Licensed Embalmer No. 4013

P. O. Address Columbia, S.C.

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.