

FILED OCT 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

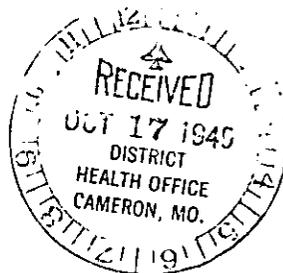
State File No. **34560**
 BIRTH NO. **59440-49** REG. DIST. NO. **251** PRIMARY REG. DIST. NO. **3048** Registrar's No. **247**

1. PLACE OF DEATH a. COUNTY Nodaway			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Worth		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryville		c. LENGTH OF STAY (in this place) 24 hours	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Grant City		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital			d. STREET ADDRESS (If rural, give location) 1		
3. NAME OF DECEASED (Type or Print) Raymond Lee Fletchall			4. DATE OF DEATH 9-30-1949		
5. SEX male		6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 1		8. DATE OF BIRTH 9-29-1949
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 24	
11. BIRTHPLACE (State or foreign country) Maryville, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Verdon Fletchall		13b. MOTHER'S MAIDEN NAME Marlene Main		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Verdon Fletchall ADDRESS Grant City, Mo.	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intracranial Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 24 hours
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			7710
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input 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?	
22. I hereby certify that I attended the deceased from 29 Sept, 1949 , to Sept 30, 1949 , that I last saw the deceased alive on Sept 30, 1949 and that death occurred at 3:00 p.m. , from the causes and on the date stated above.					
23a. SIGNATURE Frank B. Madison M.D.			23b. ADDRESS Grant City, Mo.		23c. DATE SIGNED Oct 6, 49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-1-1949		24c. NAME OF CEMETERY OR CREMATORY Fletchall Cemetery	
				24d. LOCATION (City, town, or county) (State) Grant City, Mo.	
DATE REC'D BY LOCAL REG. 10-15-49		REGISTRAR'S SIGNATURE Bess Holt		25. FUNERAL DIRECTOR'S SIGNATURE Arch C. Dangle ADDRESS Grant City, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48



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 Arch C. Dunfee

Licensed Embalmer No. 3262

P. O. Address Grant City, 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.