

FILED JUL 16 1951

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22624

BIRTH NO. _____ REG. DIST. NO. 103 PRIMARY REG. DIST. NO. 4175 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hornesville</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hornesville</u>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <u>0350</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>None</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Virginia</u> b. (Middle) <u>Agusta</u> c. (Last) <u>Letner</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6-2-51</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 26, 1876</u>
9. AGE (In years last birthday) <u>74</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Ark.</u>
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Bill Haneline</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
13c. NAME OF HUSBAND OR WIFE <u>John Letner</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>None</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) <u>BRONCHOECTASIS</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4200</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		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 <u>MAY</u> , 1951, to <u>JUNE</u> , 1951, that I last saw the deceased alive on <u>JUNE 1</u> , 1951, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>William E. Park M.D.</u>		23b. ADDRESS <u>Cornwell mo.</u>	
23c. DATE SIGNED <u>6/18/51</u>			
24. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-4-51</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Pickel Park</u>		24d. LOCATION (City, town, or county) (State) <u>Pickel Ark</u>	
DATE REC'D BY LOCAL REG. <u>6-29-51</u>		REGISTRAR'S SIGNATURE <u>Bertha Kinschling</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Service</u>		ADDRESS <u>Pay B.B. Baird Mar</u>	

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

350
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RECEIVED DUNKLIN COUNTY HEALTH
DEPARTMENT 7-3-51
COUNTY FILE NUMBER 751-177

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.

Signed.....

Hubert A. Baine

.....
Student Embalmer

Licensed Embalmer No. 806

P. O. Address Cadwell, 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.