

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24128**

FILED AUG 7 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **299** PRIMARY REG. DIST. NO. **60 28** Registrar's No. **9**

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

1. PLACE OF DEATH a. COUNTY <b>Reynolds</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Reynolds</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Rural, Lesterville</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Rural, Lesterville Twsp.</b>	
c. LENGTH OF STAY (In this place) <b>life</b>		d. STREET ADDRESS (If rural, give location) <b>9 mi. Northwest of Lesterville</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>9 mi. Northwest of Lesterville</b>		e. FULL NAME OF HOSPITAL OR INSTITUTION <b>9 mi. N.W. of Lesterville</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>LETTIE</b>		b. (Middle) <b>FREZETTA</b>	
c. (Last) <b>SHRUM</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>July 18 1951</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Sept. 4 1867</b>
9. AGE (In years last birthday) <b>83</b>	10. UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <b>10 14</b>	11. BIRTHPLACE (State or foreign country) <b>Reynolds Co. Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Henry Shrum</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Jonas H. Shrum</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Ottis Shrum, Monterey Mo.</b>		ADDRESS	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Enteritis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Valvular heart trouble</b> DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4214</b>	
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 <b>July 17, 1951</b> , to <b>July 18, 1951</b> , that I last saw the deceased alive on <b>July 18, 1951</b> , and that death occurred at <b>6.20</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>E. M. Fitzpatrick M.D.</b>		23b. ADDRESS <b>Reynolds Mo</b>	
23c. DATE SIGNED <b>7/18/51</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>A burial</b>		24b. DATE <b>7-20-51</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Chapman Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Monterey Mo.</b>	
DATE REC'D BY LOCAL REG. <b>7/24/51</b>		REGISTRAR'S SIGNATURE <b>E. M. Fitzpatrick</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>White Funeral Home</b>		ADDRESS <b>Ironton Mo.</b>	

RECEIVED

AUG 4 1951

DISTRICT HEALTH OFFICE No.

File No.....

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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.....

*Russell White*

Licensed Embalmer No. *3012*

P. O. Address.....

*Sanitar Inc*

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.