

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. CRANFORD 28278
State File No. 816-A

FILED SEP 8 - 1953

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 816-A

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOWELL</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEST PLAINS</u> <u>0461</u>	
c. LENGTH OF STAY (in this place) <u>1 DAY</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BURGE HOSP.</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>LEILA</u>	b. (Middle) <u>ANN</u>	c. (Last) <u>CHARLES</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 26, 1953</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>SEPT. 18 1951</u>	9. AGE (In years last birthday) <u>1</u>	10 UNDER 1 YEAR Months <u>-</u>	11 UNDER 1 WEEK Days <u>-</u>	12 UNDER 1 MIN. Hours <u>-</u>	13 MIN. <u>-</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>WEST PLAINS, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>THOMAS GAYLE CHARLES</u>	13b. MOTHER'S MAIDEN NAME <u>TRULA ODELL</u>	14. NAME OF HUSBAND OR WIFE <u>X</u>
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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>NO</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>THOMAS G. CHARLES WEST PLAINS, MO.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Burns 3° - 80% of body surface - house fire</u>		
	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. <u>NONE</u>		E 9160 16	

19a. DATE OF OPERATION <u>NONE</u>	19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) COUNTY, STATE <u>West Plains, Howell, Mo.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug 24, 1953 8:00</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>House fire</u>
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22. I hereby certify that I attended the deceased from Aug 25, 1953, to Aug 26, 1953, that I last saw the deceased alive on Aug 26, 1953, and that death occurred at 7 P. M., from the causes and on the date stated above.

23a. SIGNATURE <u>Edwin L. Clayton M.D.</u>	23b. ADDRESS <u>109 Professional Bldg. Springfield</u>	23c. DATE SIGNED <u>8/28/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>08/29/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>NEAR WEST PLAINS, MO</u>	24d. LOCATION (City, town, or county) (State) <u>WEST PLAINS, MO.</u>
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DATE REC'D BY LOCAL REG. <u>8-31-53</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. LOHMEYER SPRINGFIELD, MO.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Walter E Hamilton

Licensed Embalmer No. 3808

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.