

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23219**

BIRTH NO. **46620-55** REG. DIST. NO. **290** PRIMARY REG. DIST. NO. **5985** Registrar's No. **85**

1. PLACE OF DEATH a. COUNTY Pulaski			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pulaski		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN US Army Hospital Fort Leonard Wood, Mo.		c. LENGTH OF STAY (in this place) 5hrs46mins	c. CITY OR TOWN US Army Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION US Army Hospital, Ft. Leonard Wood, Mo.			e. STREET ADDRESS (If rural, give location) Fort Leonard Wood, Missouri		
3. NAME OF DECEASED (Type or Print) a. (First) Nancy b. (Middle) Ann c. (Last) Fitler			4. DATE OF DEATH (Month) (Day) (Year) July 15 1955		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) ---	8. DATE OF BIRTH July 14, 1955	9. AGE (In years last birthday) Months Days 5 0 0	IF UNDER 14 HRS. Hours Min. 5 46
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	11. BIRTHPLACE (City and State or Foreign Country) Fort Leonard Wood, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Robert D. Fitler		13b. MOTHER'S MAIDEN NAME Frances Allen		14. NAME OF HUSBAND OR WIFE ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. ---	17. DECEASED'S SIGNATURE OR NAME AND ADDRESS C.B. Milligan, Maj, MSC Fort Leonard Wood, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Internal hydrocephalus ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 752X II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Spina. Bifida				INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				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)	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 July 14, 1955 , to July 15, 1955 , that I last saw the deceased alive on July 15, 1955 , and that death occurred at 01:07a.m. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) [Signature]			23b. ADDRESS US Army Hospital, Ft. Leonard Wood		23c. DATE SIGNED July 15, 55
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7/16/1955	24c. NAME OF CEMETERY OR CREMATORY Unknown	24d. LOCATION (City, town, or county) (State) Vicksburg Mississippi		
DATE REC'D BY LOCAL REG. 7-16-55	REGISTRAR'S SIGNATURE [Signature]	458	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS [Signature] HEDGES FUNERAL HOMES INC CROCKER		

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

Family Residence - Route 2, Box 177-A
Vicksburg, Mississippi

Date Filed 7-23-55
File Number 7-23-55
Pulaski County Health Officer
RECEIVED 7-16-55

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.....
Signature of Student Embalmer

Signed *Clarence Shross*

Licensed Embalmer No. 489

P. O. Address *W. Agnew*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.