

with, self, public service

00  
57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

00

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

24222

FILED JUL 22 1957

STATE FILE NUMBER  
Registrar's No. **716**

Registration District No. 128 Primary Registration District No. 2000

|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Greene</b>  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Greene</b>                        |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Springfield</b>   |                                   | c. CITY OR TOWN <b>Springfield</b> <i>0396</i>  |   |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                                   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>1819 W. Chestnut</b>  |                                   | d. STREET ADDRESS (If outside, give location)<br><b>1810 W. Chestnut</b>  |   |
| Length of stay in 1b <b>29 yrs.</b>   |                                   | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LELA</b> Middle <b>BERNICE</b> Last <b>WHITWORTH</b>  |                                   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>14</b> Year <b>1957</b>                              |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 3, 1912</b>   |
| 9. AGE (In years last birthday) <b>45</b>   |                                   | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HRS.<br>Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  | 11. BIRTHPLACE (City and state or country) <b>Clark, South Dakota</b>                             |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                   | 13a. FATHER'S NAME <b>Leonard Fullerton</b>   |   |
| 13b. MOTHER'S MAIDEN NAME <b>Delpha Hoover</b>  |                                   | 14. NAME OF HUSBAND OR WIFE <b>Deceased</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                   | 16. SOCIAL SECURITY NO. <b>none</b>   | 17. INFORMANT Address<br><b>Mrs. Delpha Langston Springfield, Mo.</b>                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple sclerosis</b>  |                                   |   | INTERVAL BETWEEN ONSET AND DEATH,<br><b>2 yrs</b><br><b>5 yrs</b>                                 |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Rheumatoid arthritis, severe</b>   |                                   |   |   |
| DUE TO (c) _____  |                                   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>345X</b>  |                                   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour _____<br>a.m. _____<br>p.m. _____   |                                   | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |   |
| 21. I attended the deceased from <b>May 20, 1950</b> to <b>July 14, 1957</b> and last saw her alive on <b>July 10, 1957</b><br>Death occurred at <b>7:00</b> <b>A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                   |   |   |
| 22a. SIGNATURE <i>M.D.</i><br>(Degree or title) <b>M. D.</b>  |                                   | 22b. ADDRESS <b>1630 N. Jefferson, Springfield, Mo.</b>   |   |
| 22c. DATE SIGNED <b>7-15-57</b>   |                                   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>July 17, 1957</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Danforth</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Springfield, Mo.</b>                          |
| 24. FUNERAL DIRECTOR<br><b>Ralph Thieme Springfield, Mo.</b>  |                                   | 25. DATE RECD. BY LOCAL REG.<br><b>7-18-57</b>  | 26. REGISTRAR'S SIGNATURE<br><i>Edith Williams</i>  |

(Licensed Embalmer's Statement on Reverse Side)

Greene No. Springfield x  
 1810 W. Chestnut Sp. Ave. x  
 LELA BERNICE WHITFORTH  
 Female White x  
 Home Clark, South Dakota U.S.A.  
 Deceased  
 Leonard Fullerton Delpha Hoover  
 Mrs. Delpha Hoover Springfield, Mo.

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 

Licensed Embalmer No. 4568  
 P. O. Address Springfield, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If not embalmed, fact should be so stated above.