

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035931

FILED VS OCT 26 1959

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. \_\_\_\_\_ Registrar's No. 1106

ENDED

1. PLACE OF DEATH a. COUNTY <b>Greené</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Republic</b>		c. CITY OR TOWN <b>Republic</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Joeseh</b> Last <b>Fletcher</b>			4. DATE OF DEATH Month <b>October</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-30-1894</b>	9. AGE (last birthday) <b>65</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		11. BIRTHPLACE (City and state or country) <b>Topeka, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>

13a. FATHER'S NAME <b>Joeseh Fletcher</b>		13b. MOTHER'S MAIDEN NAME <b>Lovilla Wilhite</b>		14. NAME OF HUSBAND OR WIFE <b>Eula Fletcher</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give year or dates of service) <b>yes WWI</b>		16. SOCIAL SECURITY NO. <b>509-05-4999</b>		17. INFORMANT <b>Eula Fletdher Republic, Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 Minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</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)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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19. WAS AUTOPSY PERFORMED? 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 Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <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 30 Sept 1959 to 16 Oct '59 and last saw her/him alive on 16 Oct 1959  
Death occurred at 7:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Karl Leidinges M.D.</b>		22b. ADDRESS <b>Republic, Mo</b>		22c. DATE SIGNED <b>10-17-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-19-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>W.B. Cantrell Republic, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>10-22-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 \_\_\_\_\_  
Signature of Student Embalmer

Signed William B. Centre

Licensed Embalmer No. 4820

P. O. Address Republic,

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.