

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037190

FILED VS NOV 6 1959 290

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 126

1. PLACE OF DEATH a. COUNTY <b>PULASKI</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WAYNESVILLE</b>	Length of stay in 1b <b>6 WKS</b>	c. CITY OR TOWN <b>NIANGUA MORZ</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>WAYNESVILLE GEN.</b>		d. STREET ADDRESS (If outside, give location) <b>5 MI NORTH</b>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>E</b> Last <b>LETTERMAN JR</b>			4. DATE OF DEATH Month <b>SEPT</b> Day <b>21</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-9-1926</b>	9. AGE (last birthday) <b>33</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INVALED</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13a. FATHER'S NAME <b>WALTER LETTERMAN SR</b>		13b. MOTHER'S MAIDEN NAME <b>PEARL C ROWE</b>		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) <b>No</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <b>WALTER LETTERMAN SR, NIANGUA</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Streptococcal Septicemia</b>		
DUE TO (b) <b>Arthritic, colitis, Anemia</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

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 <b>Richland, MO.</b>		COUNTY _____ STATE _____

21. I attended the deceased from **APRIL 1959** to **DEATH** and last saw him <sup>her</sup> alive on **SEPT. 21-1959**.  
Death occurred at **7:10 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	22b. ADDRESS <b>Richland, MO.</b>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>9-21-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GOOD SPRINGS</b>
23d. LOCATION (City, town, or county) <b>WEBSTER CO MO</b>	23e. DATE RECD. BY LOCAL REG. <b>10-27-59</b>	23f. REGISTRAR'S SIGNATURE <i>[Signature]</i>
24. FUNERAL DIRECTOR <b>BARBER-EDWARDS MARSHFIELD</b>	24a. ADDRESS	24b. DATE RECD. BY LOCAL REG.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*R. W. Bode*

Licensed Embalmer No. \_\_\_\_\_

38

P. O. Address \_\_\_\_\_

*W. B. Bode*

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.