

S. No. 2
 OM-2-43
 Rev. 5-17-39
 X35697

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30543

State File No.

Registrar's No. 697

FILED SEP 25 1945
 Registration District No. 128

Primary Registration District No. 5466

1. PLACE OF DEATH:
 (a) County Greene
 (b) City or town Rural in S. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
OZARK Osteopathic Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Greene 39
 (c) City or town Springfield, 2
(If outside city or town limits, write "RURAL")
 (d) Street No. 478 E. Harrison 6
(If rural, give location)
 (e) Citizen of foreign country? Yes (or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Laura Virginia Cummins
 3. (b) If veteran, name war Unknown
 3. (c) Social Security No. Unknown

4. Sex Female / 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Unknown
 6. (c) Age of husband or wife if alive DEE years
 7. Birth date of deceased October 18, 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>76</u>	<u>10</u>	<u>14</u>		hr. min.

9. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation In Home

11. Industry or business _____

MOTHER FATHER
 12. Name Joseph H. Lettsinger
 13. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Jane Grody
 15. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Bessie Allison
 (b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof Sept. 3, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Hazelwood Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
 (b) Address Springfield, Missouri

19. (a) 9-4-45 (b) J. W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 2,
 year 1945 hour 3:45 minute A. M.
 21. I hereby certify that I attended the deceased from 4-7-45
 1945 to 9-1- 1945
 that I last saw her alive on Sept. 1, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative heart failure
Due to Hypertension + age
(Pulmonary cancer)
 Duration ?
 Due to _____
 Due to _____

Other conditions 920
(Include pregnancy within 3 months of death)

Major findings: None performed
 Of operations _____
 Of autopsy None performed
 PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature Walter J. Wilcox (M. D. or other) MD
 Address Springfield, Mo. Date signed 9/3/45
(Specify type of place) (e) Means of injury ?

(Licensed Embalmer's Statement on Reverse Side)

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

39
 0
 0

954

AUG 26 1954

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *L. A. Roof*

Licensed Embalmer No. *3044*

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 this body is not embalmed, fact should be so stated above.