

FILED NOV 28 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36528**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1044

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>5 years</u>	c. CITY OR TOWN <u>Springfield</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Havner Rest Home, 722 E Elm</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <u>722 E. Elm</u>	

3. NAME OF DECEASED (Type or Print) <u>LETITIA</u>	a. (First)	b. (Middle)	c. (Last) <u>DAY</u>	4. DATE OF DEATH <u>November 20 1955</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>Sept 6, 1856</u>	9. AGE (in years last birthday) <u>99</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Burlington, Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Samuel W. Day</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Hunt</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs C. M. Bloodgood, Springfield, Mo.</u>	ADDRESS _____
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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		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senile atrophy of heart</u>		
	ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>		
	DUE TO (b) <u>senility</u>		
	DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		
	<u>malnutrition</u>		<u>1 yr.</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 October 19 50, to Nov. 19 55, that I last saw the deceased alive on Nov. 19 55, and that death occurred at 3:15P m., from the causes and on the date stated above.

23a. SIGNATURE <u>Leilie B. West</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>609 Cherry, Springfield, Mo.</u>	23c. DATE SIGNED <u>11/21/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 23, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Robberson Prairie</u>	24d. LOCATION (City, town, or county) (State) <u>North, Springfield, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>11-23-55</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Jewell G. Windle, Springfield, Mo.</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Robert E. Nephew*

Licensed Embalmer No. *4916*

P. O. Address *Springfield*

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.