

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013580
STATE FILE NUMBER

FILED MAY 6 1958 Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 31

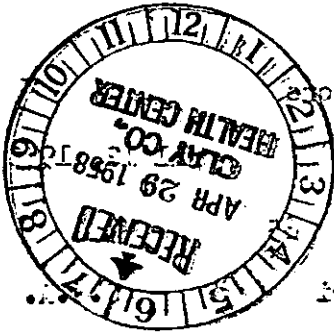
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Clay			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 0890 a. STATE Missouri b. COUNTY Ray		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Excelsior Springs, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Orrick		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Veterans Administration		Length of stay in lb 13 days	d. STREET ADDRESS (If outside, give location) none		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CECIL Middle O. Last FLETCHER			4. DATE OF DEATH Month April Day 12 Year 1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-92	9. AGE (In years birthday) 65	FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Orrick, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John Fletcher		13b. MOTHER'S MAIDEN NAME Leannah Stokes		14. NAME OF HUSBAND OR WIFE Mary Fletcher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Address VA Hospital records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis, bilateral, lower lobes					INTERVAL BETWEEN ONSET AND DEATH 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Pulmonary emphysema, severe					22 years
DUE TO (c) 5271					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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. Attended the deceased from March 30, 1958 to April 12, 1958 and James C. Stroff on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) S.C. STROFF, M.D.			22b. ADDRESS Excelsior Springs, Missouri		22c. DATE SIGNED 4-12-58
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-14-58	23c. NAME OF CEMETERY OR CREMATORY SOUTH POINT		23d. LOCATION (City, town, or county) (State) ORRICK, MISSOURI
24. FUNERAL DIRECTOR GOOD FUNERAL HOME, ORRICK, MO		25. DATE RECD. BY LOCAL REG. 4-20-58		26. REGISTRAR'S SIGNATURE Baroline Hutchings	



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 _____

Signed *Ralph Van Landingham*

Signature of Student Embalmer

Licensed Embalmer No. *4009*

P.O. Address *Spring Springs, Ohio*

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.