

TC-04-406 2-20-04

## SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

## 1. Article Addressed to:

St. John's Regional Medical  
Center  
2727 McClelland Blvd.  
Joplin, MO 64804

## COMPLETE THIS SECTION ON DELIVERY

## A. Signature

*Xylene Williamson* ☒ Agent ☐ Addressee

## B. Received by (Printed Name)

*Xylene W*

## C. Date of Delivery

*2/24/04*

D. Is delivery address different from item 1? ☐ Yes

If YES, enter delivery address below: ☒ No

## 3. Service Type

- ☒ Certified Mail ☐ Express Mail  
☐ Registered ☐ Return Receipt for Merchandise  
☐ Insured Mail ☐ C.O.D.

## 4. Restricted Delivery? (Extra Fee)

☐ Yes

## 2. Article Number

(Transfer from service label)

7001 1940 0002 6942 6270

UNITED STATES POSTAL SERVICE



First-Class Mail
Postage & Fees Paid
USPS
Permit No. G-10

• Sender: Please print your name, address, and ZIP+4 in this box •

**FILED**

MO PUBLIC SERVICE COMMISSION FEB 27 2004

P.O. BOX 360

JEFFERSON CITY, MO

Missouri Public  
Service Commission

02+0360

