

FILED APR 25 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. **2000**

Registrar's No. **295**

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

1. PLACE OF DEATH:

(a) County **GREENE**  
(b) City or town **SPRINGFIELD**  
(c) Name of hospital or institution: **1828 N. MAIN**  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_

3. (a) PRINT FULL NAME **EUGENE M. LECKIE**

3. (b) If veteran, name war **UNK.** 3. (c) Social Security No. **UNK.**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **UNK.**  
6. (b) Name of husband or wife **UNK.** 6. (c) Age of husband or wife if alive **UNK.** years  
7. Birth date of deceased **June UNK. 1886**

8. AGE: Years **58** Months **10** Days **UNK.** If less than one day hr. min.

9. Birthplace **UNK.** **UNK.** 9 (City, town, or county) (State or foreign country)

10. Usual occupation **SALESMAN**

11. Industry or business **2ND HAND DEALER**

MOTHER FATHER { 12. Name **JOHN M. LECKIE**  
13. Birthplace **FINCASTLE VA. 1**  
14. Maiden name **HANNIE E. UNK.**  
15. Birthplace **UNK. VA. 1**

16. (a) Informant **Wla Lauch**

(b) Address **Fair Grove, Mo. R# 2**

17. (a) **Burial** (b) Date thereof **Apr. 14, 1945**

(c) Place: burial or cremation **Maple Park Cem.**

18. (a) Signature of funeral director **J. W. Klingner Co**

(b) Address **Springfield, Mo.**

19. (a) **4-13-45** (b) **J. W. Klingner**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **GREENE**  
(c) City or town **SPRINGFIELD**  
(d) Street No. **1828 N. MAIN**  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **APRIL** 8th day year **1945** hour **12** minute **30** AM.

21. I hereby certify that I attended the deceased from **4-8-45** to **4-8-45** that I last saw him alive on **4-8-45** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion** Duration **1 hr.**

Due to **arterio sclerosis**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy **gfw**

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **W. T. Walsh** (M. D. or other) \_\_\_\_\_ Address **Springfield, Mo.** Date signed **4/9/45**

MAY 20 1952

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

*May Rhodes*

Licensed Embalmer No.....

4021

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.