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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 3 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4016

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 259

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 Minutes
In this community Entire lifetime. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 911 Olive Street
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME RALPH WALTER LEAVERTON JR.
3. (b) If veteran, name war World War 2
3. (c) Social Security No. 498-24-8134
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased November (Month) 26th. (Day) 1926 (Year)

8. AGE: Years 20 Months 2 Days 19 If less than one day hr. min.

9. Birthplace St. Joseph, (City, town, or county) Missouri. (State or foreign country)
10. Usual occupation Salesman.
11. Industry or business Automobile.

FATHER
12. Name Ralph W. Leaverton Sr.
13. Birthplace Gallatin, Missouri. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Alice White
15. Birthplace Bedford, Iowa. (City, town, or county) (State or foreign country)

16. (a) Informant Ralph W. Leaverton Sr.
(b) Address 911 Olive Street
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-47 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Auburn Cemetery
18. (a) Signature of funeral director Mrs E. R. Sidenfaden
(b) Address 602 South 10th. Street
19. (a) 2-26-47 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15th year 1947 hour 3 minute 45 A M.
21. I hereby certify that I attended the deceased from Feb 15th 1947, to, 19; that I last saw h alive on, 19; and that death occurred on the date and hour stated above.
Immediate cause of death Injuries received in an Auto Collision
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

Duration

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) Accident
(b) Date of occurrence Feb 15th 1947
(c) Where did injury occur? Rural Buchanan County (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place (Specify type of place)
While at work? No (e) Means of injury Auto
23. Signature B. W. Tadlo C/S Coroner (M. D. or other)
Address KING HILL BLDG Date signed 2/15/47

(Licensed Embalmer's Statement on Reverse Side) St. Joseph, Mo.
Call with Motor Vehicle

382

APR 10 1947

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 Mollie E. Sidenfaden Fox

Licensed Embalmer No. 4235

P. O. Address St. Joseph 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.