

FILED JUN 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15549**

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BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **483**

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>LAWRENCE</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SPRINGFIELD, MO.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>LOGAN</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>O'REILLY VA HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>GENERAL DELIVERY</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>PERCIE</b> b. (Middle) <b>P.</b> c. (Last) <b>LEACH</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>MAY 29, 1949</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JULY 16, 1895</b>	9. AGE (In years last birthday) <b>55</b>	IF UNDER 1 YEAR (Months) <b>10</b> IF UNDER 24 HRS. (Day) <b>13</b> IF UNDER 1 MIN. (Hour) _____ (Min.) _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>		11. BIRTHPLACE (State or foreign country) <b>ATWOOD, TENNESSEE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>					

13a. FATHER'S NAME <b>WAYET LEACH</b>		13b. MOTHER'S MAIDEN NAME <b>MARY BROOKS</b>		14. NAME OF HUSBAND OR WIFE <b>MAE LEACH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW ONE</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <b>VA RECORDS, SPRINGFIELD, MISSOURI</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>MEDICAL CERTIFICATION Brights Disease, acute.</b>		INTERVAL BETWEEN ONSET AND DEATH  <b>590X</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Lymphosarcoma, history of.</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) (Min.)	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 **MAY 16**, 19**49**, to **MAY 29**, 19**49**, that I last saw the deceased alive on **MAY 29**, 19**49**, and that death occurred at **7:00p.** m., from the causes and on the date stated above.

23a. SIGNATURE <b>P. L. EISELE, M. D.</b> (Degree or title)	23b. ADDRESS <b>VA HOSPITAL, SPRINGFIELD, MO.</b>	23c. DATE SIGNED <b>5-29-49</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>5-30-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Cracker</b>
		24d. LOCATION (City, town, or county) (State). <b>Cracker MO</b>

DATE REC'D BY LOCAL REG. <b>5-31-49</b>	REGISTRAR'S SIGNATURE <b>W. E. Handley</b>	FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>Gorman-Schuyf, Springfield Mo</b>
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

APR 17 1951

**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 .....  
Student Embalmer

Signed

*Levin G. Schaff*

Licensed Embalmer No. *3802*

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 this body is not embalmed, fact should be so stated above.