

FILED JUN 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

18899

179

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

BIRTH NO. _____		REG. DIST. NO. <u>386</u>		PRIMARY REG. DIST. NO. <u>5-209</u>		Registrar's No. <u>5-</u>	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (When deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>CARROLL</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Leslie</u>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL - Leslie</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>				d. STREET ADDRESS (If rural, give location) <u>5-ma West of Bogard</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ruby</u>		b. (Middle) <u>LEAKEY</u>		c. (Last) <u>McIntosh</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 11 1949</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Nov 23, 1884</u>	
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR (Months) (Days) <u>6 18</u>		IF UNDER 24 HRS. (Hours) (Mins.)			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ray Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Wm. Leakey</u>		13b. MOTHER'S MAIDEN NAME <u>Ruby Little</u>		14. NAME OF HUSBAND OR WIFE <u>Wm. Thomas McIntosh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Lloyd McIntosh Tina Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of the left breast.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>about 3 yrs.</u>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES (b) <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>				DUE TO (b) <u>Hospital data at the</u>	
		DUE TO (c) <u>Ellis Fischer.</u>				DUE TO (c) <u>Ellis Fischer.</u>	
		II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) <u>none</u>				170X	
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 <u>April 1, 1949</u> , to <u>June 12, 1949</u> , that I last saw the deceased alive on <u>June 5, 1949</u> , and that death occurred at <u>9:00 m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>D. Hamilton Hester, M.D.</u>				23b. ADDRESS <u>Fairview Haven, Norborne, Mo.</u>		23c. DATE SIGNED <u>June 12, 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-13-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Fairview Haven</u>		24d. LOCATION (City, town, or county) (State) <u>Norborne, MO</u>	
DATE REC'D BY LOCAL REG. <u>June 13-49</u>		REGISTRAR'S SIGNATURE <u>Emmie Street</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. Edwards</u>		ADDRESS <u>Bogard MO</u>	

RECEIVED JUN 20
District Health Officer No. 8,

District File Number.....

Date Filed 6-21-49

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.

Signed E. A. Decker

Signed.....
Student Embalmer

Licensed Embalmer No. 2534

P. O. Address Boyard

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.