

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29380**

FILED SEP 26 1949

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1016**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Harrison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Coffey	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital #2		d. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED (Type or Print) a. (First) Leni b. (Middle) _____ c. (Last) TOOMBS			4. DATE OF DEATH (Month) (Day) (Year) Sept 18 1949		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 31 1885	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 5 Days 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Frank Easton		13b. MOTHER'S MAIDEN NAME Clara Flint		14. NAME OF HUSBAND OR WIFE Blaine Toombs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Mrs Myron Hall Coffey Missouri	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 year 5 yrs 4-2-21
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Chronic		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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) na	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) _____	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 **Nov 15, 1948, to 9-18, 1949**, that I last saw the deceased alive on **9-17, 1949**, and that death occurred at **2:52 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS State Hospital #2		23c. DATE SIGNED 9-18-1949	
24a. BURIAL, CREMATION, REMOVAL (Specify) B	24b. DATE Sept 20 1949	24c. NAME OF CEMETERY OR CREMATORY Antioch	24d. LOCATION (City, town, or county) (State) Bethany Harrison MO		
DATE REC'D BY LOCAL REG. Sept 19, 1949	REGISTRAR'S SIGNATURE E. C. Jenkins 382	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS W. H. Noble New Hartford MO			

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

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 John

Student Embalmer No.

working under my personal supervision.

Signed W. G. Kelle

Signed
Student Embalmer

Licensed Embalmer No. 2964

P. O. Address New Hampton MS

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.