

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32492**

FILED OCT 18 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **1** PRIMARY REG. DIST. NO. **3000** Registrar's No. **270**

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Macon</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kirkville</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Atlanta</b> <b>0610</b>	
c. LENGTH OF STAY (by this place) <b>7 days</b>		d. STREET ADDRESS (If rural, give location) <b>1</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Grim Smith Memorial Hosp.</b>			

3. NAME OF DECEASED (First) <b>ROBERT</b>		b. (Middle) <b>EARL</b>		c. (Last) <b>LEA</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 10 1950</b>	
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5. SEX <b>0</b> <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>M. 1</b>	8. DATE OF BIRTH <b>DEC 21-1885</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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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	11. BIRTHPLACE (State or foreign country) <b>Macon Co. Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>BRADLEE LEA</b>	13b. MOTHER'S MAIDEN NAME <b>DELICENA ARNETT</b>	14. NAME OF HUSBAND OR WIFE <b>MRS LOUISE LEA</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown). (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Louise Lea Atlanta Mo</b>	ADDRESS
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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 <b>10-20 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>INTESTINAL Obstruction due</b>		<b>6 months?</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>to carcinoma Rectum</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>154X</b>	

19a. DATE OF OPERATION <b>10-9-50</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)	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 **10-3**, 1950, to **10-10**, 1950, that I last saw the deceased alive on **10-10**, 1950, and that death occurred at **12:40 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Blondie M.D. Kirkville Mo</b>	(Degree or title)	23b. ADDRESS <b>Kirkville Mo</b>	23c. DATE SIGNED <b>10-12-50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Oct 12 1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Labor</b>	24d. LOCATION (City, town, or county) (State) <b>Atlanta Rye Township Mo</b>
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DATE REC'D BY LOCAL REG. <b>10-14-50</b>	REGISTRAR'S SIGNATURE <b>Kate Lambert</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>H M Gooding Atlanta Mo</b>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0013

DEC 29 1955

Date Received: OCT 15 1950  
DISTRICT HEALTH OFFICE #2  
District File Number 10-50-1  
Date Filed: OCT 17 1950

**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 H. M. Goodding

Licensed Embalmer No. 1750

P. O. Address Atlanta, 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.