S. No. 300
EV. 10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 23 1952

State File No. 18

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 12

1. PLACE OF DEATH
a. COUNTY: ADAIR
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kirksville
c. LENGTH OF STAY (In this place): 7 mo, 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Community Nursing Home #1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewistown 0560
d. STREET ADDRESS (If rural, give location): UNKNOWN

3. NAME OF DECEASED (Type or Print)
a. (First): Lucy
b. (Middle): Elnora
c. (Last): Leach

4. DATE OF DEATH (Month) (Day) (Year): 1-11-52

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 4-30-1867
9. AGE (In years last birthday): 84 — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maywood, Mo.
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: William Nund
13b. MOTHER'S MAIDEN NAME: Elizabeth Harrison
14. NAME OF HUSBAND OR WIFE: Albert Leach

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Henry Nund, Lewistown, Mo.

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.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Anoxia — Interval between onset and death: 3 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart Failure — 8 mos.
DUE TO (c) Hypertensive Cardiovascular Disease — Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): None
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) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 443X

22. *I hereby certify that I attended the deceased from* June 6, 1951, *to* Jan. 11, 1952, *that I last saw the deceased alive on* Jan. 11, 1952, *and that death occurred at* 5:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: M. T. Gutenschn (Degree or title) D.O.
23b. ADDRESS: Kirksville, Mo.
23c. DATE SIGNED: Jan. 12, 1952

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/14/52
24c. NAME OF CEMETERY OR CREMATORY: Dover Cem.
24d. LOCATION (City, town, or county) (State): Scotland County Mo.

DATE REC'D BY LOCAL REG.: 1-14-52
REGISTRAR'S SIGNATURE: Kate Lambert
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert B. Davis Kirksville, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 .....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirksville, 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.