

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9183

State File No.

No. 300
10-48

FILED APR 7 1953

BIRTH NO. _____		REG. DIST. NO. <u>75</u>		PRIMARY REG. DIST. NO. <u>3015</u>		Registrar's No. <u>27</u>	
1. PLACE OF DEATH a. COUNTY <u>Clinton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>MO</u> b. COUNTY <u>Clinton</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Cameron</u>		c. LENGTH OF STAY (If in this place) <u>17 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>CAMERON</u>		OR TOWN <u>N. 0251</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cameron Community Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>Streu Nursing Home</u>			
3. NAME OF DECEASED (Type or Print) <u>C. LATE</u>		a. (First)		b. (Middle) <u>Leard</u>		c. (Last)	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>1879-MAY-20</u>	
9. AGE (In years last birthday) <u>73</u>		If UNDER 1 YEAR Months <u>10</u> Days <u>10</u>		If UNDER 100 Hrs. Hours <u>10</u> Min. _____		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>30</u> (Year) <u>53</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED GROCER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>JAMES LEARD</u>		13b. MOTHER'S MAIDEN NAME <u>REBECCA OWENS</u>		14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>X</u> (If yes, give war or dates of service) <u>X</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Henry Fleming Weather</u> ADDRESS _____			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Cardiac decompensation</u> ANTECEDENT CAUSES <u>Chronic myocarditis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
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) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4222</u>			
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 <u>3-26-53</u> to <u>3-30</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>3-29</u> , 19 <u>53</u> and that death occurred at <u>4:30 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>W. W. Moser</u> (Degree or title) _____				23b. ADDRESS <u>Winston, Mo.</u>		23c. DATE SIGNED <u>3-30-53</u>	
24a. BURIAL CREMATION-REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3-31-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ALTA VISTA</u>		24d. LOCATION (City, town, or county) (State) <u>Winston Mo.</u>	
DATE REC'D BY LOCAL REG. <u>4-2-53</u>		REGISTRAR'S SIGNATURE <u>Winnifred W. Moser</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Palmer</u>		ADDRESS <u>Streu Nursing Home</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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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 F. Poland

Licensed Embalmer No. 4777

P. O. Address 222 West 3th St
Lawson 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.