No. 300
10.48

0840
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25913

State File No.

FILED AUG 13 1953

BIRTH NO. REG. DIST. NO. 282 PRIMARY REG. DIST. NO. 5972 Registrar's No. 98

1. PLACE OF DEATH
a. COUNTY: Polk
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Flemington
c. LENGTH OF STAY (In this place): All Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Missouri
b. COUNTY: Polk
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Flemington 0840
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Howard
c. (Last): Leffler

4. DATE OF DEATH (Month) (Day) (Year): 8-4-53

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 16 1882
9. AGE (In years last birthday): 70 — 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): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (City and State or Foreign Country): Hickory County Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: J. E. Leffler
13b. MOTHER'S MAIDEN NAME: Lucy Dear
14. NAME OF HUSBAND OR WIFE: Hazel Martha Leffler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): *
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: Hazel Leffler Flemington, Mo.

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

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: 4500
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1947 *to* Aug, 1953, *that I last saw the deceased alive on* Aug 1, 1953, *and that death occurred at* 2:05 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: P. G. McClear
(Degree or title): MD
23b. ADDRESS: P. Bolivar
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-6-53
24c. NAME OF CEMETERY OR CREMATORY: Flemington Cemetery
24d. LOCATION (City, town, or county) (State): Flemington Missouri

DATE REC'D BY LOCAL REG.: AUG 13 1953
REGISTRAR'S SIGNATURE: Clyde A. Bridges
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Beckwith Funeral Home Humansville

(Licensed Embalmer's Statement on Reverse Side)

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 O. H. Beckwith

Licensed Embalmer No. 3937

P. O. Address Hurnanville

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.