

FILED NOV 15 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33617**

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 1029			
1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		d. STREET ADDRESS (If rural, give location) 2353 North Lyon Avenue			
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital									
3. NAME OF DECEASED (Type or Print) a. (First) BERTHA			b. (Middle) ELLEN		c. (Last) LEISHING		4. DATE OF DEATH (Month) (Day) (Year) Nov. 6, 1954		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Nov. 18, 1880		9. AGE (In years last birthday) 73 if UNDER 1 YEAR: Months _____ Days _____ if UNDER 1 MRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress			10b. KIND OF BUSINESS OR INDUSTRY Garment		11. BIRTHPLACE (City and State or Foreign Country) Washington, Kansas			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Joseph Gray			13b. MOTHER'S MAIDEN NAME Matilda Vinsonhaler			14. NAME OF HUSBAND OR WIFE J. Ruben Leishing (Dec.)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 491-03-4629		17. INFORMANT'S SIGNATURE OR NAME Mrs. Faye Rhodes ADDRESS Springfield, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage, Right Internal Capsule ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive-arteriosclerotic DUE TO (c) Heart Disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma, Left Kidney						INTERVAL BETWEEN ONSET AND DEATH 48 hours 18 months 2 years	
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION 443 X H						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) none		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 April, 1953 , to November, 1954 , that I last saw the deceased alive on Nov. 6, 1954 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.									
23a. SIGNATURE William J. Paul, M.D. (Degree or title)				23b. ADDRESS 609 Cherry, Springfield			23c. DATE SIGNED 11/6/54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/8/1954		24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		24d. LOCATION (City, town, or county) (State) Springfield, Missouri			
DATE REC'D BY LOCAL REG. 11-12-54		REGISTRAR'S SIGNATURE Paula Williamson			FUNERAL DIRECTOR'S SIGNATURE Harry Clyde ADDRESS Springfield, Mo				

(Licensed Embalmer's Statement on Reverse Side)

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

62 West Walnut

STATEMENT BY LICENSED EMBALMER

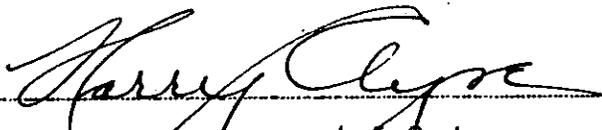
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. 4594

P. O. Address Springfield, 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.