

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28618**

FILED AUG 16 1955

BIRTH NO. _____		REG. DIST. NO. <u>324</u>		PRIMARY REG. DIST. NO. <u>3072</u>		Registrar's No. <u>150</u>	
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Marshall</u>		c. LENGTH OF STAY (In this place) <u>3 yrs.</u>		c. CITY OR TOWN <u>Marshall</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>661 E. Thomas</u>				e. STREET ADDRESS (If rural, give location) <u>661 E. Thomas</u>			
3. NAME OF DECEASED (Type or Print) <u>ROBERT</u>		a. (First)		b. (Middle)		c. (Last) <u>LEACH</u>	
4. DATE OF DEATH <u>Aug. 7, 1955</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 7, 1881</u>		9. AGE (In years last birthday) <u>74</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Cameron, Missouri</u>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Rosa Leach</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Rosa Leach Marshall, Mo.</u>			
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>Coronary thrombosis with atherosclerosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>None</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral hemiplegia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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>June 10, 1954</u> , to <u>Aug 7, 1955</u> , that I last saw the deceased alive on <u>Jan 5, 1955</u> , and that death occurred at <u>5:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Ralph H. Jones M.D.</u>				23b. ADDRESS <u>Marshall Mo.</u>		23c. DATE SIGNED <u>8-15-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 10, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Shilo Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Saline Co., Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Aug 11-55</u>		REGISTRAR'S SIGNATURE <u>Carl J. Reed</u>		385-0 Deputy <u>Harry Bersberger</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Marshall, Mo.</u>	

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.....
Signature of Student Embalmer

Signed.....
Joseph R. Marshall

Licensed Embalmer No. 45

P. O. Address *Marsh*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.