

STANDARD CERTIFICATE OF DEATH

State File No. **29480**

FILED SEP 19 1955

BIRTH NO. **62231-55** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **805**

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution) a. STATE Mo b. COUNTY Douglas	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY OR TOWN Drew, Mo.	
c. LENGTH OF STAY (in this place)		d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital		e. STREET ADDRESS (If rural, give location) 0340	

3. NAME OF DECEASED a. (First) David b. (Middle) Herald c. (Last) Leroy			4. DATE OF DEATH (Month) (Day) (Year) Sept 10, 1955		
5. SEX Male	6. COLOR OF RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH Sept 19, 1955	9. AGE (In years) (Month) (Day) 0 0 0	10. IF UNDER 1 YEAR 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Child	11. BIRTHPLACE (City and State or Foreign Country) Intn. Home, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Joe Leroy	13b. MOTHER'S MAIDEN NAME Ella May Hurst	14. NAME OF HUSBAND OR WIFE Child
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. NO.
17. INFORMANT'S SIGNATURE OR NAME Joe Leroy		ADDRESS Drew 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 16 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Promaturity		
	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. Congenital Atelectasis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 7625
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 **9-9-**, 19**55**, to **9-10-**, 19**55**, that I last saw the deceased alive on **9-10-**, 19**55**, and that death occurred at **2:00 A.m.**, from the causes and on the date stated above.

23a. SIGNATURE Paul Busick	(Degree or title) M.D.	23b. ADDRESS Springfield, Mo	23c. DATE SIGNED 9/29/55
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 9-11-55	24c. NAME OF CEMETERY OR CREMATORY New Hope	24d. LOCATION (City, town, or county) (State) Drew Mo
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DATE REC'D BY LOCAL REG. 9-12-55	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE Frank W. ...	ADDRESS Int'l Home Mo
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(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
Signature of Student Embalmer

Signed *Frank Gable*

Licensed Embalmer No. *414*

P. O. Address *mtu Pa*

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.