

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39889**

FILED DEC 28 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **5191** Registrar's No. **52**

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cape Girardeau</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Rural, Applebrook Twp. P.</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Raisin Mo. Rural Applebrook</b>	
c. LENGTH OF STAY (in this place) <b>T.M.P.</b>		d. STREET ADDRESS (If rural, give location) <b>No St address</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>No St address</b>		e. STREET ADDRESS <b>No St address</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>ALVIN</b> b. (Middle) <b>LEINE</b> c. (Last) <b>LEINE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Dec 17 1955</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>w</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 19 1882</b>
9. AGE (In years last birthday) <b>73</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>28</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>New Wells Mo</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			

13a. FATHER'S NAME <b>August Leine</b>	13b. MOTHER'S MAIDEN NAME <b>Louise Martin</b>	14. NAME OF HUSBAND, OR WIFE <b>Clara Hickman</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>unk</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Walter Leine Raisin Mo.</b>

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Failure</b>		<b>24 hr</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Carcinoma of Stomach</b>		<b>5 yr</b>
	DUE TO (c) <b>Gastric Ulcer 15 1/2 X</b>		<b>15 yr.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Non-functioning Gall Bladder</b>		<b>15 yr.</b>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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)
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 **August, 1955**, to **December, 1955**, that I last saw the deceased alive on **Nov 20, 1955**, and that death occurred at **1:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>A. W. Nicholson D.O.</b>	23b. ADDRESS <b>Jackson, Mo.</b>	23c. DATE SIGNED <b>12/17/55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Dec 19, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Friedheim Cemetery, Friedheim Mo.</b>
24d. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>McCombs 446 Jackson Mo</b>	
DATE REC'D BY LOCAL REG. <b>12-23-55</b>	REGISTRAR'S SIGNATURE <b>C. C. Summers</b>	

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

0160

DEC 29 1965

**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 B A Meyer

Licensed Embalmer No. 30571

P. O. Address Jackson 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.