

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **270**
Registrar's No. **2**

FILED JAN 9 1956

REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 4 yrs.		d. STREET ADDRESS (If rural, give location) 616 1/2 Shady Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 616 1/2 Shady Ave.			
3. NAME OF DECEASED a. (First) Leslie b. (Middle) - c. (Last) Everett			4. DATE OF DEATH (Month) (Day) (Year) 1-2-56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 8, 1879
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer	11. BIRTHPLACE (State or foreign country) Clinton Co. Mo
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME David Everett		13b. MOTHER'S MAIDEN NAME Hettie Creek	14. NAME OF HUSBAND OR WIFE Mrs. Julia Everett
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME, ADDRESS Mrs. Julia Everett, 616 1/2 Shady Ave. City
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) Cerebral Vascular Accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4221	
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) m.	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 , 19 55 , to January 2 , 19 56 , that I last saw the deceased alive on 1-2 , 19 56 , and that death occurred at 8:00 P. M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Richard A. Muehle, M.D.		23b. ADDRESS 1218 N. 2nd St., City	23c. DATE SIGNED 1-2-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-4-56	24c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.	24d. LOCATION (City, town, or county) (State) Clinton Co. Mo
DATE REC'D BY LOCAL REG. Jan 3, 1956	REGISTRAR'S SIGNATURE Lothar M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE WE Summers ADDRESS St. Louis	

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

JAN 10 1956

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

W.E. Summersfield

Licensed Embalmer No. *3007*

P. O. Address *Stuartsville, Md*

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.