FILED MAR 23 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10318

BIRTH NO. 64269-56 REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 4457 Registrar's No. 22

1. PLACE OF DEATH
a. COUNTY St. Clair
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural- Lowry City
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Center Township

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY St. Clair
c. CITY OR TOWN Rural- Lowry City
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location) Center Township 0920

3. NAME OF DECEASED (Type or Print) a. (First) Leland b. (Middle) Ray c. (Last) Zeiler

4. DATE OF DEATH (Month) (Day) (Year) March 13, 1956

5. SEX Male 0
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 0
8. DATE OF BIRTH Nov; 7, 1955
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 4 Days 6 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Clinton Missouri 0
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Marvin Zeiler
13b. MOTHER'S MAIDEN NAME Mary Davis
14. NAME OF HUSBAND OR WIFE --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Marvin Zeiler, Lowry City Missouri ADDRESS

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thymus Enlarged

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.

INTERVAL BETWEEN ONSET AND DEATH.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 273X
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 10:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE Ruth Sievers (Degree or title) MD 0
23b. ADDRESS
23c. DATE SIGNED 3-15-56

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 3/15/56
24c. NAME OF CEMETERY OR CREMATORY Osceola
24d. LOCATION (City, town, or county) (State) Osceola Missouri

DATE REC'D BY LOCAL REG. 3-15-56
REGISTRAR'S SIGNATURE Ruth Sievers
25. FUNERAL DIRECTOR'S SIGNATURE Goodrich Funeral Home ADDRESS Osceola Mo

(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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed F. B. Goodrich.....

Licensed Embalmer No. 30

P. O. Address Osce

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.