

Health,
Welfare
Public
Service

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Doctor, coroner, etc., must use only standard nomenclature in return to this form. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1012

STATE FILE NUMBER

FILED FEB 11 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 137

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE				
b. CITY (If outside corporate limits, give TOWNSHIP only) SPRINGFIELD			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 901 N. WARREN			Length of stay in lb 47 yrs	d. STREET ADDRESS (If outside, give location) 901 N. WARREN			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEEMON				First	Middle	Last	4. DATE OF DEATH Month Feb. Day 5, Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1877		9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Frisco Railroad Employee			10b. KIND OF BUSINESS OR INDUSTRY mm	11. BIRTHPLACE (City and state or country) Webster Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Calvin Rice				14. MOTHER'S MAIDEN NAME Mary J. Crawford				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.	17. INFORMANT Address Roy Rice, 923 E. Madison				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Coronary Occlusion							INTERVAL BETWEEN ONSET AND DEATH Unknown	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							UNATTENDED BY PHYSICIAN 4261	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of item 18.)					
20c. TIME OF INJURY Hour p. m. Month, Day, Year								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. Attended the deceased from _____ to _____ and last saw her <u>him</u> alive on _____ Death occurred at about 1:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Edith Williamson (Degree or title) Local Registrar of Vital Statistics				22b. ADDRESS Greene County Court House Springfield, Missouri		22c. DATE SIGNED 2/7/57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/7/57	23c. NAME OF CEMETERY OR CREMATORY Shields Cemetery		23d. LOCATION (City, town, or county) (State) Webster Co., Missouri			
24. FUNERAL DIRECTOR AYRE-GOODWIN FUNERAL SERVICE Springfield				25. DATE RECD. BY LOCAL REG. 2-7-57	26. REGISTRAR'S SIGNATURE Edith Williamson			

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

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 *Levin T. Swadlow*

Licensed Embalmer No... *48*

P. O. Address *Levin T. Swadlow*

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.