

Health, Welfare, Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED FEB 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **4163**

Registration District No. **96** Primary Registration District No. **4158** Registrar's No. **35**

1. PLACE OF DEATH a. COUNTY Dallas		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY Dallas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Buffalo Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Buffalo ⁰³⁰⁰ / ₀ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION Sho-me Rest Home Length of stay in lb		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Leary ^{First} - ^{Middle} Doyle ^{Last}			4. DATE OF DEATH 2-15-1957 ^{Month} ^{Day} ^{Year}			
5. SEX Female	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 2-15-1881	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR ^{Months} ^{Days} ^{Hours} ^{Min.}	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and state or country) Miller Co. Mo, U.S.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown			
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 Ray Doyle ^{Address} Junas, Mo.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia			INTERVAL BETWEEN ONSET AND DEATH 7 days 1 year 10 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chronic Myocarditis		
	DUE TO (c) Arteriosclerosis		
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"/>

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 or Part II of item 18.)		
20c. TIME OF INJURY ^{Hour} ^{Month, Day, Year} ^{a. m.} ^{p. m.}					
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. I attended the deceased from **1946** to **2-15-57** and last saw her ^{from} alive on **2-15-57**
Death occurred at **7:30 P** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Clare O. Shannon M.D.	22b. ADDRESS Buffalo, Mo	22c. DATE SIGNED 2-16-57
---	---------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/17/1957	23c. NAME OF CEMETERY OR CREMATORY Hope Well	23d. LOCATION (City, town, or county) (State) Dallas County, Mo.
24. FUNERAL DIRECTOR Montgomery Funeral Home Mo. ADDRESS Buffalo		25. DATE RECD. BY LOCAL REG. 2/18/57	26. REGISTRAR'S SIGNATURE Mrs Grace Petree

(Licensed Embalmer's Statement on Reverse Side)

247A

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 *Elyde Montgomery*

Licensed Embalmer No. *35*

P. O. Address *Buffalo,*

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.