

Health,  
Welfare  
Public  
Service

FILED MAY 29 1957

THE STANDARD CERTIFICATE OF DEATH

18280

STATE FILE NUMBER

Registration District No. 294 Primary Registration District No. 3006 Registrar's No. 115

1. PLACE OF DEATH a. COUNTY <u>RANDOLTH</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>MADISON</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MOBERLY</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ALTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>M<sub>o</sub> Cormick HOSPT.</u>			Length of stay in lb <u>8 Days</u>	d. STREET ADDRESS (If outside, give location) <u>11 East 11th</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>HOMER CALVIN LEAKE</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>14th</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DECEMBER 29th 1927</u>		9. AGE (In years last birthday) <u>29</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>15</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORATORY TECHNICIAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>MONROE CITY, MISSOURI.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL CLARENCE LEAKE</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA N GREEVES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>327-22-7457</u>		17. INFORMANT Address <u>Mrs. Homer Leake Alton Ill</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medulary Fibrosis</u> DUE TO (b) <u>Diabetic Myelitis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>260X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
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.) <u></u>				
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>							
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.) <u></u>		20f. CITY, TOWN, OR LOCATION <u></u>			COUNTY <u></u>
21. I attended the deceased from <u>5-6-57</u> to <u>5-14-57</u> and last saw <u>him</u> alive on <u>5-14-57</u> Death occurred at <u>745</u> <u>P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Dr. J. J. Gally D.O.</u>				22b. ADDRESS <u>2203 1/2 N Clark Moberly Mo</u>		22c. DATE SIGNED <u>5-15-57</u>	
23a. BURIAL, CREMATION, or other disposition (Specify) <u>BURIAL</u>	23b. DATE <u>MAY 16th 57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST JUDES CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONROE CITY, MISSOURI</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Wilson &amp; Sons MONROE CITY, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>5-16-57</u>		26. REGISTRAR'S SIGNATURE <u>Leakebrowne</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

300  
1-56

300  
1-56

JUN 4 1957  
JUN 13 1957

JUN 22 1957

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 *Lester L. Wilcox* .....

Licensed Embalmer No. *30*

P. O. Address *Monroe, La.*

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.