

Public Health Service

300 -56

Causes of death must be stated in Part I. If death due to natural causes, coroner cannot certify to a death due to natural causes.

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FILED JUL 8 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2048

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 240

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
D. S. Baker

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Columbia</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>213 W. Ash St.</u>			Length of stay in lb <u>2 Mos.</u>	d. STREET (If outside, give location) ADDRESS <u>Rector's Nursing H.</u>			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>W.</u> Last <u>Kleasner</u>				4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>57</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>Oct. 29, 1891</u>		9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (City and state or country) <u>St. Charles County Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>F. H. Kleasner</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Middlebrook</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. -----		17. INFORMANT Address <u>Mrs. Bernard Lyle Columbia, Mo.</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>Cerebral hemorrhage & m.a.</u> DUE TO (b) <u>arteriosclerosis, severe</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITIONS GIVEN IN PART II <u>gangrene of great toe</u>							INTERVAL BETWEEN ONSET AND DEATH <u>33IX</u>	
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"/>							
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
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 <u>Jan 19 1957</u> to <u>June 27 57</u> and last saw <u>him</u> alive on <u>June 26, 1957</u> . Death occurred at <u>9:26 P. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>James M. Palmer M.D.</u> (Degree or title)				22b. ADDRESS <u>Columbia Mo.</u>		22c. DATE SIGNED <u>June 29 57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>6-29-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) <u>Columbia, Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Lyman Sprinkle Columbia, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>June 29 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R E Palmer</u>			

(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, [REDACTED] Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Lynnan H. Spunkle*

Licensed Embalmer No. *40*

P. O. Address *Columbia*

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.