

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 JUL 29 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

23623

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 822

1. PLACE OF DEATH a. COUNTY <u>Buchanan County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Davies</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>St. Joseph</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Coffey</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #2</u>		Length of stay in lb <u>1 mo. 2 dys</u>	d. STREET ADDRESS (If outside, give location) <u>0310</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>George W.</u> Middle <u>Leaverton</u> Last <u>Leaverton</u>			4. DATE OF DEATH Month <u>July</u> Day <u>26</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>8/25/1872</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
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		11. BIRTHPLACE (City and state or country) <u>Savannah, Missouri</u>		
13. FATHER'S NAME <u>William Leaverton</u>			14. MOTHER'S MAIDEN NAME <u>Loucind Wetzel</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>None</u>		17. INFORMANT Address <u>State Hosp. #2 Records, St. Joseph, 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>Syphilis of Cardiovascular and Central nervous system</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
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"/> <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.)	
20c. TIME OF INJURY Hour _____ a. m. _____ 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. I attended the deceased from <u>July 22</u> to <u>July 26</u> and last saw ^{her} him alive on <u>July 26</u> Death occurred at <u>10:25</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Mohammad [Signature] M.D.</u>	22b. ADDRESS <u>1415 N. 24 St.</u>	22c. DATE SIGNED <u>7-26-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-27-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Coffey Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Coffey Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>J. Beckman Mollan</u>		25. DATE RECD. BY LOCAL REG. <u>July 26, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</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; or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *L. O. Richardson*.....

Licensed Embalmer No. *33*

P. O. Address *Halla*

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.