

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32296

FILED SEP 26 1957

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 411

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo		b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Independence		c. LENGTH OF STAY (in this place) 15 days		c. CITY OR TOWN Oak Grove	
d. FULL NAME OF HOSPITAL OR INSTITUTION Independence San & Hospital		STREET ADDRESS (If rural, give location) 2 Miles South			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Leka M	b. (Middle) Mae	c. (Last) Larche	(Month) Sept	(Day) 16	(Year) 1957

5. SEX F M	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb 5 1904	9. AGE (In years less birthday) 53	IF UNDER 1 YEAR Months 0	IF UNDER 12 HRS. Days 0	IF UNDER 24 HRS. Hours 0	IF UNDER 1 MIN. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Eros Louisiana		12. CITIZEN OF WHAT COUNTRY USA		

13a. FATHER'S NAME J. A Fuller	13b. MOTHER'S MAIDEN NAME Gertrude Phillips	14. NAME OF HUSBAND OR WIFE Earl Larche
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Earl Larche	ADDRESS Oak Grove Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 15 day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Basilar artery		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 332X	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE? (Specify)	21b. PLACE OF INJURY (e.g., is or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-1, 1957, to 9-16, 1957; that I last saw the deceased alive on 9-15, 1957, and that death occurred at 5:04 a.m., from the causes and on the date stated above.

23a. SIGNATURE John W. Williams M.D.	23b. ADDRESS Oak Grove, MO	23c. DATE SIGNED 9/17/57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-18 1957	24c. NAME OF CEMETERY OR CREMATORY Oak Grove	24d. LOCATION (City, town, or county) (State) Oak Grove Mo
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DATE REC'D BY LOCAL REG. 9-18-57	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Webb Funeral Home Oak Grove Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

540

OCT 7 1957

SEP 23 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: *R. Blubb*

Licensed Embalmer No. *235*

P. O. Address *Blue Springs*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure 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.