

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-039176  
STATE FILE NUMBER

FILED DEC 9 1958

Registration District No. 53 Primary Registration District No. \_\_\_\_\_ Registrar's No. 546

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>CAPE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CAPE</u>	
b. CITY OR TOWN <u>ALLENVILLE</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>HAFLIN MO</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS <u>RFD #1</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSIE ETTA LEGGETT</u>			4. DATE OF DEATH Month Day Year <u>Nov. 11-1958</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>10-10-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>ALLENVILLE MO</u>
13a. FATHER'S NAME <u>JOHN DEVORE</u>		13b. MOTHER'S MAIDEN NAME <u>SUSIE SCHULTZ</u>	14. NAME OF HUSBAND OR WIFE <u>JOHN LEGGETT</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT Address <u>John Leggett Allen, 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>Coronary occlusion</u> DUE TO (b) <u>Asthma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>241X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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>Feb 14-56</u> to <u>Nov 11-58</u> and last saw her alive on <u>Nov 11-58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wm. L. Lavelle M.D. Delta Mo</u>		22b. ADDRESS <u>Delta Mo</u>	
22c. DATE SIGNED <u>Nov 18 58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-13-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOLLINGER COUNTY</u>	23d. LOCATION (City, town, or county) (State) <u>LUTESVILLE MO</u>
24. FUNERAL DIRECTOR <u>STUBBS' FUNERAL HOME</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 1, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Homer Cooper</u>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Eugene I. Stubbs* .....

Licensed Embalmer No. *5012* .....  
P. O. Address *Chaffee Mo* .....

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.