

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006596

STATE FILE NUMBER

MAR 16 1959 Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 93

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sedalia</u> <u>0846</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>Campbell Nursing Home 70yrs</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>522 West 7th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Blanche</u> Last <u>Leach</u>			4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18 1879</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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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>Columbus Miss.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Charles A Sheaffer</u>	13b. MOTHER'S MAIDEN NAME <u>Alice Smith</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Leach</u>
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15. WAS DECEASED EVER IN U. S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Miss Rabie Schaeffer</u> Address <u>522 W. 7th</u> <u>Sedalia</u>
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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>Aspiration pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Parkinson's disease</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>Severe Rheumatoid Arthritis 350X</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"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ 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
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21. I attended the deceased from <u>7 April 1955</u> , to <u>9 March 1959</u> and last saw her alive on <u>9 March 1959</u> Death occurred at <u>3:55 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Donald C. [Signature]</u> (Degree or title)	22b. ADDRESS <u>Sedalia Mo.</u>	22c. DATE SIGNED <u>3/13/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-11-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>	23d. LOCATION (City, town, or county) <u>Sedalia</u>	(State) <u>Mo</u>
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24. FUNERAL DIRECTOR <u>M<sup>c</sup>Laughlin Bros. Sedalia</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>3-14-1959</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
1-57

All diseases in Part I must be causally related.

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 *K.P.M. [Signature]* .....

Licensed Embalmer No. *3153* .....  
P. O. Address *Sedalia T.* .....

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.