

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010171

STATE NUMBER

FILED MAR 23 1959

Registration District No. 209

Primary Registration District No. 3040

Registrar's No. 79

300
-57

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		c. CITY OR TOWN Hannibal <i>06-464</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Grants rest home		d. STREET ADDRESS (If outside, give location) XXXX So. Arch St.	
3. NAME OF DECEASED (Type or print) Wallace Leewright		4. DATE OF DEATH Month 3 Day 14 Year 59	
5. SEX Male <i>2</i>	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 29 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Greenville Kentucky
13a. FATHER'S NAME Tom Leewright		13b. MOTHER'S MAIDEN NAME Hattie Black	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 487-14-2468	17. INFORMANT <i>Louise M. Grant</i> Address 928 S. Arch St
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331x			INTERVAL BETWEEN ONSET AND DEATH
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.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to 3-6-59 and last saw her alive on 3-6-1959 Death occurred at 3-6-59 5:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>E.M. Lucke</i> (Degree or title) M.D.		22b. ADDRESS 910 Broadway Hannibal	
22c. DATE SIGNED 3-19-59			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
Burial		3-19-59	
23c. NAME OF CEMETERY OR CREMATORY Robinson cemetery		23d. LOCATION (City, town, or county) (State) Hannibal Mo.	
24. FUNERAL DIRECTOR W.R. Sephus ADDRESS Hannibal Mo		25. DATE RECD. BY LOCAL REG. 3/19/59	
26. REGISTRAR'S SIGNATURE <i>E.M. Lucke By M.C. Fisher</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *M. R. Seehus*

Licensed Embalmer No. *3420*

P. O. Address *Kennel*

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.