

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010396

STATE FILE NUMBER

FILED MAR 30 1959

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 110

Health,  
Welfare  
Public  
Service

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sedalia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Sedalia</b> <b>0804</b> C
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1401 South Sneed</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>1401 South Sneed</b>
3. NAME OF DECEASED (Type or print) First <b>PEARL</b> Middle <b>MAE</b> Last <b>LESSLEY</b>			4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1884</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owm Home</b>	9. AGE (In years last birthday) <b>75</b>
11a. FATHER'S NAME <b>James R. Stout</b>		11b. MOTHER'S MAIDEN NAME <b>Sally Smith</b>	11. BIRTHPLACE (City and state or country) <b>Lamonte, Mo.</b>
12. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		13. SOCIAL SECURITY NO. <b>none</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
14. NAME OF HUSBAND OR WIFE <b>William A. Lessley</b>		17. INFORMANT Address <b>Mrs. Herman Chancey, Rt. 1, Sedalia, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Accident</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hyper tension</b>			<b>5-6 yrs.</b>
DUE TO (c) <b>Arteriosclerosis</b>			<b>10-12 yrs.</b>
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"/>
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 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 <b>5-15-58</b> , to <b>3-22-59</b> and last saw her alive on <b>3-22-59</b> Death occurred at <b>4:40 p.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>D.K. Kirby D.O.</b>		22b. ADDRESS <b>814 W. 16th Sedalia Mo.</b>	22c. DATE SIGNED <b>3-23-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/24/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Sedalia, Mo.</b>
24. FUNERAL DIRECTOR <b>Funeral Home</b>		ADDRESS <b>Sedalia, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Mar 24 1959</b>
26. REGISTRAR'S SIGNATURE <b>Frances Shelby</b>			

(Licensed Embalmer's Statement on Reverse Side)

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 *Rhane Ewing* .....

Licensed Embalmer No. *384* .....  
P. O. Address *Delaware* .....

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.