

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016546

STATE FILE NUMBER

FILED APR 23 1959

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 60

300  
-57

2

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Springfield Mo</u> 0396 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>State Hospital</u>		Length of stay in lb <u>2 mo 2 days</u>	d. STREET ADDRESS (If outside, give location) <u>928 South Jefferson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> - Middle Last <u>LEACH</u>			4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1959</u>
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>July 22, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>67</u> F UNDER 1 YEAR Months <u>8</u> Days <u>17</u> IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
11. BIRTHPLACE (City and state or country) <u>9</u>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>George Orrick</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Rice</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		14. NAME OF HUSBAND OR WIFE <u>W.A. Leach</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Records State Hospital Nevada Mo</u> Address	
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>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis</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)			INTERVAL BETWEEN ONSET AND DEATH <u>several years</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 <u>no</u> 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>Jan 19, 1955</u> to <u>April 8/59</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>April 8, 1959</u> Death occurred at <u>7:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Paul L Barone M.D.</u>		22b. ADDRESS <u>Nevada State Hospital - Mo</u>	
		22c. DATE SIGNED <u>April 8/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>April 8,</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fillington</u>	
		23d. LOCATION (City, town, or county) (State) <u>Fillington, Mo.</u>	
24. FUNERAL DIRECTOR <u>Ralph Thieme</u>		25. DATE RECD. BY LOCAL REG. <u>4-14-1959</u>	
ADDRESS <u>Springfield, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Anna B. Perry</u>	

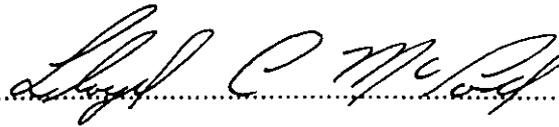
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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  .....

Licensed Embalmer No. 4853 .....

P. O. Address Florida, 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.