

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016821  
STATE FILE NUMBER 595

FILED JUN 15 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No.

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		Length of stay in 1b 60 years	d. STREET ADDRESS (If outside, give location) 1302 S. 20th
6		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last John Leonardo			4. DATE OF DEATH Month Day Year June 5 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1867	9. AGE (In years last birthday) 91	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Ret.)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Calascibetta Sicily	12. CITIZEN OF WHAT COUNTRY? Italy
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13a. FATHER'S NAME Francis Leonardo	13b. MOTHER'S MAIDEN NAME Maria Pecora	14. NAME OF HUSBAND OR WIFE Rosalia
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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.	17. INFORMANT Mrs. Frank Leonardo, St. Joseph Mo.
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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>Myocardial Infarct</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
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.) 4201
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. 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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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>May 29 - 1959</u> to <u>June 5 - 59</u> and last saw <u>him</u> alive on <u>June 5 - 1959</u> Death occurred at <u>4:20 P</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Alvin W. Stearns MD</u> (Degree or title)	22b. ADDRESS <u>312 Kirkatons Bldg St. Joseph, Mo</u>	22c. DATE SIGNED <u>6/6/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 8, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet, Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
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24. FUNERAL DIRECTOR <u>H.A. Sidenbader &amp; Son St. Joseph, Mo. June 8, 1959</u> <u>n. w. R.</u>	25. DATE RECD. BY LOCAL REG. <u>June 8, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Wm. Clark Goodell</u>
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(Licensed Embalmer's Signature on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Craig

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 *W. William Davis* .....

Licensed Embalmer No. *4195* .....

P. O. Address *St. Joseph, 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.