

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017487

STATE FILE NUMBER

MAY 18 1959 Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 195

300
1-57

1. PLACE OF DEATH a. COUNTY HENRY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY HICKORY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLINTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Quincy MO
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION CLinton GENL Hospt 2 hours		Length of stay in lb 2 hours	d. STREET ADDRESS (If outside, give location) 0 0430 NONE
3. NAME OF DECEASED (Type or print) First Middle Last HANNIE VICTORIA LEIBER		4. DATE OF DEATH Month Day Year MAY 14 1959	
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/1889
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		9b. KIND OF BUSINESS OR INDUSTRY NONE	9c. AGE (In years last birthday) 69
10a. FATHER'S NAME JAMES HENRY HART		10b. MOTHER'S MAIDEN NAME VICTORIA E. CROSS	10c. NAME OF HUSBAND OR WIFE WALLACE LEIBER
11. BIRTHPLACE (City and state or country) HICKORY Co MO		12. CITIZEN OF WHAT COUNTRY? USA	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		14. SOCIAL SECURITY NO. none	15. INFORMANT Wallace Leiber Address Quincy MO
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO (b) Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day
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 WORK <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 May 14, 1959 to May 14, 1959 and last saw her alive on May 14, 1959 Death occurred at 1:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE A. M. [Signature] (Deceased or titler)		22b. ADDRESS 106 S. 3rd, Clinton, MO.	22c. DATE SIGNED 15 May '59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/17/1959	23c. NAME OF CEMETERY OR CREMATORY MT ZION CEM	23d. LOCATION (City, town, or county) (State) Quincy MO
24. FUNERAL DIRECTOR Hathaway Wheeland ADDRESS 2nd		25. DATE RECD. BY LOCAL REG 5-15-59	26. REGISTRAR'S SIGNATURE Mildred Bigum

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 20 1959

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 *J. E. Consalus*

Licensed Embalmer No. *1891*
P. O. Address *Clinton*

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.