

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018419

STATE FILE NUMBER

FILED MAY 25 1959 Registration District No. 206 Primary Registration District No. 5TH5 Registrar's No. 28

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| 1. PLACE OF DEATH a. COUNTY MADISON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Madison | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CENTRAL TWP- Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN FREDERICKTOWN Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 10 mi. S.W. of FREDERICKTOWN Length of stay in lb 7 mos. | | d. STREET ADDRESS (If outside, give location) <input checked="" type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|--|----------------------------------|---|--|---|---|--|---------|
| 3. NAME OF DECEASED (Type or print) First OSCAR Middle LEAMON Last LEE | | | 4. DATE OF DEATH Month MAY Day 9 Year 1959 | | | | |
| 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 AUG. 14, 1875 | 9. AGE (In years last birthday) 83 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL LABOR | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) KENTUCKY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME STEPHEN H. LEE | | | 14. MOTHER'S MAIDEN NAME EDNA WEAVER | | | | |
| 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. NONE | | 17. INFORMANT STEVE LEE - FREDERICKTOWN, MO. | | | Address |

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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) Congestive heart failure | | INTERVAL BETWEEN ONSET AND DEATH years |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) investigated by Coroner Ray Wilson | | |
| DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) H341 | | |
| 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |

| | | |
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| 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. 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 _____ to _____ and last saw her alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

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|---|--------------|--------------------------------------|
| 22a. SIGNATURE (Deaf or blind) Flarence Hicks - Reg. Registrar Fredericktown, Mo. | 22b. ADDRESS | 22c. DATE SIGNED 5-11-1959 |
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| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL | 23b. DATE MAY 10, 1959 | 23c. NAME OF CEMETERY OR CREMATORY CENTRAL CEMETERY | 23d. LOCATION (City, town, or county) (State) MADISON COUNTY, MO. |
| 24. FUNERAL DIRECTOR J. Leamon | ADDRESS FREDERICKTOWN, MO. | 25. DATE RECD. BY LOCAL REG. 5-11-1959 | 26. REGISTRAR'S SIGNATURE Flarence Hicks |

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FORM NO. 229-25

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 *Raymond B. Wilson*.....

Licensed Embalmer No. 482

P. O. Address *Fredrick*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.