

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018432
STATE FILE NUMBER

FILED MAY 21 1959 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 141

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Marion				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Hannibal		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Levering Hosp,			Length of stay in 1b Life		d. STREET ADDRESS (If outside, give location) 0644 2105 Hope		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle Leeson Last Leeson				4. DATE OF DEATH Month April Day 26 Year 1959				
5. SEX F	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 March 4.1877		9. AGE (In years last birthday) 82 IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home			10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and state or country) Oshkosh, Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Charles Day			13b. MOTHER'S MAIDEN NAME Frances Jane Audwes			14. NAME OF HUSBAND OR WIFE Unk.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mr. Robert Anderson 2300 Hope St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 3 days		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) nutritional anemia								
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.)					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		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 18 April 1959 to 26 April 1959 and last saw her alive on 26 April 1959 Death occurred at 5:00 PM m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Myrtle Hamlin MD				22b. ADDRESS Hannibal Mo.		22c. DATE SIGNED 5/8/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 29.1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Hannibal Missouri			
24. FUNERAL DIRECTOR ADDRESS Jankel & Son, 1000 Broadway			25. DATE RECD. BY LOCAL REG. 5-12-59		26. REGISTRAR'S SIGNATURE Dr. E.M. Lucke By W.C. Fisher			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Jack Sullivan*
Licensed Embalmer No. *4900*
P. O. Address *Summit*

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.