

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028570

FILED VS SEP 9 1959

Registration District No. 098 Primary Registration District No. \_\_\_\_\_ Registrar's No. 76

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Daviess</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Daviess</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural Union Township</b>		Length of stay in 1b <b>12 Yrs.</b>		c. CITY OR TOWN <b>Rural Union Township</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1/2 Mi. N. Gallatin</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1/2 Mi. N. Gallatin</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hans</b> Middle <b>Leunberger</b> Last _____				4. DATE OF DEATH Month <b>About August</b> Day <b>7</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-7-1888</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (City and state or country) <b>Wisachen Switzerland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA Since 1919</b>		
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>Unknown if any</b>		17. INFORMATION <b>Registration card from Alien Immigrants, found on person</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
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) _____					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 _____ 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 <b>No medical attention</b> to _____ and last saw her/him alive on _____ Death occurred at <b>Unknown</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>P. Baumgardner M.D. Coronar Pathologist</b>				22b. ADDRESS <b>Gallatin, Missouri</b>		22c. DATE SIGNED <b>8-29-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-28-1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brown Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Gallatin, Missouri</b>		
24. FUNERAL DIRECTOR <b>Hope Funeral Home, Gallatin, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>8-5-1959</b>		26. REGISTRAR'S SIGNATURE <b>Hugh M. Englebert</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 26 1951

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by or by Was Not Embalmed, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed L. O. Richesson

Licensed Embalmer No. 3302

P. O. Address Galatia

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