

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032444

FILED OCT 13 1959 149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 4650 STATE FILE NUMBER

DED

|  |  |   |   |  |  |  |                              |
|--|--|---|---|--|--|--|------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> |  |  |                              |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>KANSAS CITY</b>  |  | Length of stay in 1b<br><b>65 yrs.</b>  |   | c. CITY OR TOWN <b>KANSAS CITY</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |                              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>V. A. HOSPITAL</b>   |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS<br><b>3329 EAST 18th STREET</b>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |                              |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>CHALMERS D. LEIGHTY</b>   |  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>SEPT 21, 1959</b>   |  |  |                              |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>       | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>4 25 90</b>   | 9. AGE (last birthday)<br><b>69 yrs.</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.                                  | IF UNDER 24 HR<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED GROCERY CLERK</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BARNARD MISSOURI</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>USA</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                                  |                              |
| 13a. FATHER'S NAME<br><b>ARTHUR LEIGHTY</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>LILLIE M. WRIGHT</b>                      |  | 14. NAME OF HUSBAND OR WIFE<br><b>MABEL LEIGHTY</b>  |  |                              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>YES WW I</b>   |  | 16. SOCIAL SECURITY NO.<br><b>492 18 3217</b>   |   | 17. INFORMANT<br>Address<br><b>VA HOSP. RECORDS K. C. MO.</b>  |  |  |                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPHYXIA</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ASPIRATED BLOODY VOMITUS</b><br>DUE TO (c) <b>BLEEDING STOMAL ULCER GASTRO JEJUNOSTOMY</b> |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |                              |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |                              |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>Hour a.m. p.m.<br>Month, Day, Year  |  |   |   |  |  |  |                              |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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>SEPT. 20 1959</b> to <b>SEPT 21, 1959</b> and last saw her/him alive on _____<br>Death occurred at <b>3.20 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |   |  |  |  |                              |
| 22a. SIGNATURE (Degree or title)<br><i>Hugh H. Owens, Coroner</i>  |  |   |   | 22b. ADDRESS<br><b>1034 Reath Bldg</b>   |  | 22c. DATE SIGNED<br><b>9-23-59</b>   |                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>  |  | 23b. DATE<br><b>SEPT 24, 1959</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT AUBURN CEM</b>                |  | 23d. LOCATION (City, town, or county)<br><b>ST. JOSEPH MO.</b>   |  | (State)                      |
| 24. FUNERAL DIRECTOR<br><b>D. W. NEWCOMER'S SONS K. C. MO.</b>   |  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>9-24-59</b>   | 26. REGISTRAR'S SIGNATURE<br><i>Neve Marshall</i>  |  |                              |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Hugh H. Owens

**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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed *B. D. Talon*

Licensed Embalmer No. 4421

P. O. Address X.C. 77

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.