

# JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 16 1959

59-035856

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1195

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>GREENE</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b <u>6 WKS</u>	c. CITY OR TOWN <u>MARSHFIELD MO</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DEYNE REST HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>239 E. JEFFERSON</u>
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>MARION T LEONARD</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>NOV 6 1959</u>		
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<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6-23-1911</u>	<b>9. AGE (last birthday)</b> <u>88</u>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HR</b> Hours Min.
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____	<b>11. BIRTHPLACE</b> (City and state or country) <u>WISCONSIN</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
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<b>13a. FATHER'S NAME</b> <u>UNKNOWN</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>	<b>14. NAME OF HUSBAND OR WIFE</b> _____
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	<b>16. SOCIAL SECURITY NO.</b> _____	<b>17. INFORMANT</b> Address <u>C.E. MCCLEAN MARSHFIELD</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Natural Cause</u> DUE TO (b) <u>Arteriosclerotic Heart Disease Unknown</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal-disease condition given in PART I (a) <u>Myocardial Fibrillation</u>	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
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____
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<b>20c. TIME OF INJURY</b> Hour a.m. p.m. _____	Month, Day, Year _____
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> _____	COUNTY STATE _____
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21. I attended the deceased from 10/16/59 to 11/6/59 and last saw her/him alive on 10/16/59  
 Death occurred at 11:10 A m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>David A. Hall</u>	<b>22b. ADDRESS</b> <u>Springfield, MO</u>	<b>22c. DATE SIGNED</b> <u>11/9/59</u>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>REMOVAL</u>	<b>23b. DATE</b> <u>11-6-1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MARSHFIELD</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>MARSHFIELD MO</u>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>BARBER-EDWARDS MARSHFIELD MO 11-12-59</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>26. REGISTRAR'S SIGNATURE</b> <u>Effie E. Mellow</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 *R. W. Bobb*

Licensed Embalmer No. 384

P. O. Address *Mt. Brown, Va.*

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.