

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001689

FILED VS JAN 25 1960

Registration District No. 149 Primary Registration District No. 1602 Registrar's No. 5 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Sullivan</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas c.t.v.</u>		Length of stay in 1b <u>DOA.</u>		c. CITY OR TOWN <u>Milan</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOA. Mercy Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leach</u> Middle <u>Leach</u> Last <u>Leach</u>				4. DATE OF DEATH Month <u>1</u> Day <u>- 2</u> Year <u>1960</u>				
5. SEX <u>fe</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-1960</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <u>2</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Milan, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Robert Leach</u>			13b. MOTHER'S MAIDEN NAME <u>Ruth -</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mercy Hospital KC, Mo.</u> Address <u></u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cause of death unknown</u> DUE TO (b) <u>Probably Bot meg. factors</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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) <u>premature Birth 7 mo.</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			
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 <u>7:50</u> Month, Day, Year <u>1/2/60</u> 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.) <u>oakwood</u>	20f. CITY, TOWN, OR LOCATION <u>Milan</u>	COUNTY <u>MO.</u>	STATE <u>MO.</u>		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>DOA 7:50 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Heidi H. Adams-Carner</u>				22b. ADDRESS <u>1534 Pratt Bldg</u>		22c. DATE SIGNED <u>1-2-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>1/2/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>oakwood</u>	23d. LOCATION (City, town, or County) <u>Milan MO.</u>					
24. FUNERAL DIRECTOR <u>Schoene's Milan, mo.</u>			ADDRESS <u>Milan, mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-2-60</u>	26. REGISTRAR'S SIGNATURE <u>Irene Marshall</u>			

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signed _____

Signature of Student Embalmer

Body not embalmed - for removal only
Dale Eaton

Licensed Embalmer No. _____

P. O. Address _____

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.