

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**60-010078**  
STATE FILE NUMBER

Registration District No. **163** REG. NO. **A2248**

Primary Registration District No. **3007** Registrar's No. **183**

FILED VS APR 4 1960

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>SCOTT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Length of stay in 1b <b>7 DAYS</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		d. STREET ADDRESS (If outside, give location) <b>206 BLACK STREET</b>	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THEON</b> Middle <b>LEO</b> Last <b>LEGRAND</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>17</b> Year <b>1960</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-16-05</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHOE</b>	11. BIRTHPLACE (City and state or country) <b>CHAFFEE, MISSOURI</b>
13a. FATHER'S NAME <b>WILLIAM LeGRAND</b>		13b. MOTHER'S MAIDEN NAME <b>LUCY GROJEONE</b>	14. NAME OF HUSBAND OR WIFE <b>AUDREY LeGRAND</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>490057223</b>	17. INFORMANT <b>WIFE</b> Address <b>MO.</b> <b>MRS. AUDREY LeGRAND, 206 BLACK ST., CHAFFEE</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>OCCCLUSION, ABDOMINAL AORTA.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>THROMBOSIS, CAUSE UNKNOWN.</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) <b>CORONARY THROMBOSIS, OLD AND RECENT.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>Unknown</b>
19. WAS AUTOPSY PERFORMED? 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 Hour _____ a.m. _____ p.m. Month, Day, Year _____		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	
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.) <b>VA</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>CHAFFEE MISSOURI</b>
21. I attended the deceased from <b>March 10, 1960</b> to <b>March 17, 1960</b> and last saw her/him <b>live on</b> Death occurred at <b>18:40PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. Name (Degree or title) <b>Ernest M. Tapp, M.D., Director, Prof. Svcs. VA Hospital, Poplar Bluff, Mo.</b>		22b. ADDRESS	22c. DATE SIGNED <b>3/18/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>MAR. 21, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. AMBROSE CATHOLIC CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>CHAFFEE, MISSOURI</b>
24. FUNERAL DIRECTOR ADDRESS <b>BISPLINGHOFF FUNERAL HOME - CHAFFEE, Mo.</b>		25. DATE RECD. BY LOCAL REG. OFF. REGISTRAR'S SIGNATURE <b>3/25/60</b> <i>[Signature]</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 5 1960

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 Jack T. Burnett  
Licensed Embalmer No. 447

P. O. Address C. Ruffee,

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.