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-60-016228

FILED VS APR 22 1960

STATE FILE NUMBER

Registration District No. 239 Primary Registration District No. 5825 Registrar's No. 9

ENDED

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Como Twsp.</u> Length of stay in 1b <u>10 years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 Mi. W. of Catron</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u> c. CITY OR TOWN <u>Catron</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1 mi. W. of Catron</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Leach</u> Last <u>Leach</u> 4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1960</u>			5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>			8. DATE OF BIRTH <u>Unknown</u> 9. AGE (last birthday) <u>Unknown</u> 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) <u>Labored</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (City and state or country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY <u>Unknown</u>		
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</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>Frank Robertson-Catron, Mo.</u> Address		
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>Possibly cardiac insufficiency</u> DUE TO (b) _____ DUE TO (c) _____ 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)						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 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 _____		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 _____ to _____ and last saw her/him alive on _____. Death occurred at <u>7 A. M.</u> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Dr. Geo W. Husted</u> (Degree or title)				22b. ADDRESS <u>local registrar Parma, Mo</u>		22c. DATE SIGNED <u>4/9/60</u> (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-3-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Simmons Burial Park</u>		23d. LOCATION (City, town, or county) <u>Near Catron, Mo.</u> (State)		
24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>4/9/60</u>		26. REGISTRAR'S SIGNATURE <u>Dr. Geo W. Husted, MD</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS APR 2 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 Harold J. Pordue

Licensed Embalmer No. 5030

P. O. Address Libham, T

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.