

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018804

FILED VS MAY 18 1960 77

Registration District No. _____ Primary Registration District No. 3016 Registrar's No. 181

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cole</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u>		Length of stay in lb <u>3 yrs. 7 mo.</u>		c. CITY OR TOWN <u>Kearney</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Prison Hospital Reg# 71601</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u></u>	
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>EuGene</u> Last <u>White</u>				4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-11-04</u>	
				9. AGE (last birthday) <u>56</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>Welder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and state or country) <u>North Platt, Neb.</u>	
						12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13a. FATHER'S NAME <u>Unknown</u>				13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Marie White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mo. State Penitentiary</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>Uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardio renal vascular Dis</u> DUE TO (c) <u>Essential Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>4 yrs</u>
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 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 _____ Month, Day, Year _____ 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____	
21. I attended the deceased from <u>4/21/60</u> to <u>5/15/60</u> and last saw her/him alive on <u>5/15/60</u> Death occurred at <u>1:58 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>[Signature]</u>				22b. ADDRESS <u>Mo. State Prison Hospital</u>		22c. DATE SIGNED <u>5/16/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem & Bur</u>		23b. DATE <u>May 17, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harrisonville Cemetary</u>		23d. LOCATION (City, town, or county) (State) <u>Harrisonville, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Victor Buescher</u>				25. DATE RECD. BY LOCAL REG. <u>16 May 1960</u>		26. REGISTRAR'S SIGNATURE <u>RP. Davis, MD - Richter, Jp.</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 _____
Signature of Student Embalmer

Signed Victor Buesche

Licensed Embalmer No. 270

P. O. Address JCM

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.