

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027832

REGISTRATION DISTRICT NO. 274 PRIMARY REGISTRATION DISTRICT NO. 3052 REGISTRAR'S NO. 273 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>	Length of stay in lb <u>20 years</u>	c. CITY OR TOWN <u>Sedalia</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1401 South Sneed</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1401 South Sneed</u>

3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM AUBREY LESSLEY</u>	4. DATE OF DEATH Month Day Year <u>Aug. 5, 1960</u>
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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>2/21/84</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	11. BIRTHPLACE (City and state or country) <u>Henry County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>G.I. Lessley</u>	13b. MOTHER'S MAIDEN NAME <u>Susan Evans</u>	14. NAME OF HUSBAND OR WIFE <u>Pearl Stout Lessley, dec'd.</u>
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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>500-10-5104</u>	17. INFORMANT Address <u>Route 1</u> <u>Mrs. Herman Chancey Sedalia, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____	<u>Pulmonary Congestion</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
	<u>Cardiac insufficiency</u>	<u>2 mo.</u>
	<u>Arteriosclerosis (General)</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Parkinson's Disease</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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
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21. I attended the deceased from 6-29-59 to 8-5-60 and last saw <sup>her</sup>him alive on 8-5-60  
Death occurred at 1:15 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Donald K. Kirby D.O.</u>	22b. ADDRESS <u>814 W. 16<sup>th</sup> Sedalia, Mo.</u>	22c. DATE SIGNED <u>8-6-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/6/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>
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24. EMBALMER DIRECTOR <u>Thane Ewing</u>	ADDRESS <u>Sedalia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 6. 1960</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

*Rhame Ewing*

Licensed Embalmer No. 3847

P. O. Address Sedalia

**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.