

UR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034030

FILED VS OCT 4 1960

STATE FILE NUMBER

Registration District No. 46 Primary Registration District No. 5152 Registrar's No. 46

1. PLACE OF DEATH a. COUNTY <u>Caldwell Co</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Caldwell</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grant Twp.</u>		Length of stay in 1b		c. CITY OR TOWN <u>Polo (Rural)</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>-</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2 1/2 mi. N.E. of Polo</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Frank</u> Last <u>Legg</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1960</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>12-5-1878</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during 1/3 of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Caldwell Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME <u>John Martin Legg</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Thomas</u>			14. NAME OF HUSBAND OR WIFE <u>Jimmie Florence Legg</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>			16. SOCIAL SECURITY NO. <u>498-40-6661</u>		17. INFORMANT <u>Miss Mildred Legg</u>				Address <u>Polo Mo</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>Cerebral vascular accident</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <u>Senility</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 _____ 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 <u>1956</u> to <u>Sept 22, 1960</u> and last saw ^{her} _{him} alive on <u>Sept 21, 1960</u> Death occurred at <u>6:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>Howard Carter M.D.</u>				22b. ADDRESS <u>Hamilton, Mo.</u>				22c. DATE SIGNED <u>Sept 23, 1960</u>		
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-24-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kingston</u>			23d. LOCATION (City, town, or county) <u>Kingston Mo</u>				
24. FUNERAL DIRECTOR <u>Alexander + Cowley Polo Mo</u>				25. DATE RECD. BY LOCAL REG. <u>Sept 26-60</u>		26. REGISTRAR'S SIGNATURE <u>Glady's Jones</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Emanuel A. Howards*

Licensed Embalmer No. 4924

P. O. Address Polo, Mo.

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.