

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034135
STATE FILE NUMBER

ED VS OCT 4 1960
INDEXED

Registration District No. 61 Primary Registration District No. 4107 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY <u>Cedar</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Cedar</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>El Dorado Springs</u>		Length of stay in 1b		c. CITY OR TOWN <u>El Dorado Springs</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>109 W. Lafayette</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>109 W. Lafayette</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Lucian</u> Middle <u>Guy</u> Last <u>Leedy</u>				4. DATE OF DEATH Month <u>September</u> Day <u>28</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>9-2-1873</u>		9. AGE (last birthday) <u>87</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>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Simon B. Leedy</u>				13b. MOTHER'S MAIDEN NAME <u>Elizabeth Martin</u>				14. NAME OF HUSBAND OR WIFE <u>Virginia Leedy</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.		17. INFORMANT Address <u>Mrs. Virginia Leedy, El Dorado Springs</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 encephalomalacia</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> 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 (-)										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 checked="" 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>1957</u> to <u>present</u> and last saw <u>him</u> alive on <u>9-27-60</u> Death occurred at <u>6:15</u> p on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Robert L. Magee, M.D.</u> (Degree or title) <u>Robert L. Magee, M.D.</u>						22b. ADDRESS <u>El Dorado Springs, Mo.</u>				22c. DATE SIGNED <u>9-29-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-2-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hazel Dell Cemetery</u>				23d. LOCATION (City, town, or county) <u>Cedar Co., Missouri</u> (State)					
24. FUNERAL DIRECTOR <u>Guinn-Carothers, El Dorado Spgs. Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>9-20</u>		26. REGISTRAR'S SIGNATURE <u>Hugh S. Allen</u> <u>Deputy</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 Wayne E. Cantrell

Licensed Embalmer No. 4419

P. O. Address E. Donald

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.