

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 26 1960

-60-034437

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 957A

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Greene</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> | | Length of stay in 1b <u>2 Days</u> | c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Handley Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>821 W. Webster</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | |
|--|--|--|---|--|
| 3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>—</u> Last <u>Leigh</u> | | | 4. DATE OF DEATH Month <u>Sept.</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>6-1-1890</u> | 9. AGE (last birthday) <u>70</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
|-----------------------|----------------------------------|---|-------------------------------------|-------------------------------------|---|--|

| | | | |
|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer & Nightwatchman</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Greene Co Mo</u> | 11. BIRTHPLACE (City and state or country) <u>U. S. A.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> |
|--|--|---|--|

| | | |
|---|---|--|
| 13a. FATHER'S NAME <u>William E. Leigh</u> | 13b. MOTHER'S MAIDEN NAME <u>Sarah Alice Swinney</u> | 14. NAME OF HUSBAND OR WIFE <u>Alta Leigh</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>Mrs Alta Leigh Springfield Mo</u> | Address <u>Springfield 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>Metastatic Ca</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| 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) | 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 <u> </u> a.m. <u> </u> p.m. <u> </u> | Month, Day, Year <u> </u> <u> </u> <u> </u> |
|---|---|

| | | | | |
|---|--|---|---------------------|--------------------|
| 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 <u> </u> | COUNTY <u> </u> | STATE <u> </u> |
|---|--|---|---------------------|--------------------|

21. I attended the deceased from 9/7/60 to 9/15/60 and last saw him alive on 9/14/60
Death occurred at 6:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|--|--|------------------------------------|
| 22a. SIGNATURE (Degree or title) <u>Leman D. Brown M.D.</u> | 22b. ADDRESS <u>311 1/2 College</u> | 22c. DATE SIGNED <u>9/17/60</u> |
|--|--|------------------------------------|

| | | | |
|--|-----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Sept. 17-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Johns Chapel Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Greene Co. Missouri</u> |
|--|-----------------------------------|--|---|

| | | | |
|---|---------------------------------|--|---|
| 24. FUNERAL DIRECTOR <u>J. W. Buch</u> | ADDRESS <u>Ash Grove Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>9-19-60</u> | 26. REGISTRAR'S SIGNATURE <u>Effie E. Meltan</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 Richard E. Watson

Licensed Embalmer No. 4657

P. O. Address Ashe Grove

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.