

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041022

FILED VS NOV 21 1960

38

Primary Registration District No. 3006

Registrar's No. 627

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Miller</u>					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbi</u>		Length of stay in 1b		c. CITY OR TOWN <u>Eldon</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>University Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>Route 3</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>Leroy</u> Last <u>Duby</u>				4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>60</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>9-25-1905</u>	9. AGE (last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u> </u> Days <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>Ret. FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Elgin, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Christian L. Duby</u>			13b. MOTHER'S MAIDEN NAME <u>Alice Bolwyn</u>		14. NAME OF HUSBAND OR WIFE <u>Goldie Ann Duby</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>486-07-6414</u>		17. INFORMANT <u>Hosp. Records</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>Coe Pulmonale</u> DUE TO (b) <u>Emphysema, Bullous</u> DUE TO (c) <u> </u> 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 (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 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> Month, Day, Year <u> </u>									
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>10-27-60</u> to <u>11-13-60</u> and last saw him <u>alive</u> on <u>11-12-60</u> Death occurred at <u>8:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Doctor or title) <u>Morris Lealon M.D.</u>					22b. ADDRESS <u>Univ. of Missouri MED Center</u>			22c. DATE SIGNED <u>11-13-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11-15-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Eldon</u>			23d. LOCATION (City, town, or county) (State) <u>Eldon, Mo.</u>			
24. FUNERAL DIRECTOR <u>Chelley's General Home Care</u>				ADDRESS <u>Nov 13 1960</u>		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 30 1950

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 James W. O'Keefe

Licensed Embalmer No. 3665

P. O. Address _____

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.