

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016786

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 62 Primary Registration District No. 5239 Registrar's No. _____

FILED JUN 12 1961

1. PLACE OF DEATH a. COUNTY <u>Cedar</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kei N N</u>		Length of stay in 1b <u>Inst.</u>	c. CITY OR TOWN <u>Arcola</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>1 mi. N. Dade-Cedar Co. line</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1/4 mi W. of Arcola</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Michael Owen Gleason</u>			4. DATE OF DEATH Month Day Year <u>June 5, 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1945</u>	9. AGE (last birthday) <u>16</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>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>		11. BIRTHPLACE (City and state or country) <u>Greenfield, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>Samuel J. Gleason</u>		13b. MOTHER'S MAIDEN NAME <u>Ola Opal Owens</u>		14. NAME OF HUSBAND OR WIFE _____	
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>Samuel J. Gleason; Arcola, Mo.</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>Multifocal Skull Fracture</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		
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Auto Accidental</u>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>6-5-61</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.) <u>Highway 39 - 1 mile N. Cedar-Dade Co. line</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Arcola, Mo.</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>3:15</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) <u>Max Pickering Corner</u>		22b. ADDRESS <u>El Dorado Spgs., Mo.</u>		22c. DATE SIGNED <u>6-5-61</u>	
23b. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23a. DATE <u>June 7, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenfield Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Greenfield, Mo.</u>	

24. FUNERAL DIRECTOR ADDRESS <u>J. C. Canada; Greenfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>June 8 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Geneva Cantlon</u>		
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

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

J. C. Canada

Licensed Embalmer No. 4196

P. O. Address Greenfield, Va

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.