

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-021341

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3016

3016

STATE FILE NUMBER

FILED JUL 5 1961

1. PLACE OF DEATH

a. COUNTY Jackson
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in 1b 5 wks
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BRATON Nursing Home Inside Limits Yes No
3400 Campbell

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY Miller
 c. CITY OR TOWN ETTERVILLE Mo. Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print)

First STELLA Middle LESLIE Last

4. DATE OF DEATH Month 6 Day 15 Year 61

5. SEX

Female

6. COLOR OR RACE

White

7. Married Never Married
 Widowed Divorced

8. DATE OF BIRTH

10-24-1879

9. AGE (last birthday)

81

IF UNDER 1 YEAR IF UNDER 24 HR
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife

10b. KIND OF BUSINESS OR INDUSTRY
—

11. BIRTHPLACE (City and state or country)
Russellville Mo.

12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

Abraham Campbell

13b. MOTHER'S MAIDEN NAME

HANNA CRUTEHFIELD

14. NAME OF HUSBAND OR WIFE

John S. LESLIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

James F. LESLIE 9500 E. 65th St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral thrombosis with left Hemiplegia

INTERVAL BETWEEN ONSET AND DEATH
6 weeks

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.

Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

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 4-26-61 to 6-14-61 and last saw her/him alive on 6-14-61

Death occurred at 7:00 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
Ralph Perry M.D.

22b. ADDRESS
4800 E. 24, Kansas City, Mo.

22c. DATE SIGNED
June 16, 1961

23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal

23b. DATE
8-16-61

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)
ELDON Mo.

24. FUNERAL DIRECTOR ADDRESS
Sheil Funeral Home K.C.Mo.

25. DATE RECD. BY LOCAL REG.
6-16-61

26. REGISTRAR'S SIGNATURE
Ruth Long

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Ralph Perry

ITEM NO. SHOULD READ

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

John P. Schell

Licensed Embalmer No. 5070

P. O. Address H. C. Ma.

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.