

OUR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037032

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5211

FILES NOV 13 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Jackson		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 3 Days		c. CITY OR TOWN Camden	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4218 Woodland		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First LOUISA		Middle SUSAN		Last LEAP		Month Day Year October 17 1961	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/1/1889	9. AGE (last birthday) 72	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Camden Co Mo		11. BIRTHPLACE (City and state or country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John West			13b. MOTHER'S MAIDEN NAME Lucinda Jackson			14. NAME OF HUSBAND OR WIFE Green Leap	
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 Address William Leap 4218 Woodland K C Mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Fractured Skull							
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 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.) Fell down stairs struck head					
20c. TIME OF INJURY Hour a.m. p.m. 10-17-61	Month, Day, Year 10-17-61	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.) Residence		20f. CITY, TOWN, OR LOCATION Camden		COUNTY Missouri		STATE MO	
21. I attended the deceased from _____ to _____ and last saw him/her live on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Hugh O. Owens Coroner				22b. ADDRESS 152 Union Station			22c. DATE SIGNED 10-18-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-18-61		23c. NAME OF CEMETERY OR CREMATORY New Hope Cemetery		23d. LOCATION (City, town, or county) (State) Camden Missouri	
24. FUNERAL DIRECTOR ADDRESS Sheil Colonial Chapel K C Mo				25. DATE RECD. BY LOCAL REG. 10-18-61		26. REGISTRAR'S SIGNATURE Ruth W. Long	

(Licensed Embalmer's Statement on Reverse Side)

10-30-61

New Hope Cemetery

DOCUMENT

MEDICAL CERTIFICATION

H. Owens

BY AFFIDAVIT OF PUBLIC HOME

New Home Cemetery

23c

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 Thomas A. Shiel

Licensed Embalmer No. 4954

P. O. Address K. P. M.

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.