

MISSOURI DEPARTMENT OF PUBLIC HEALTH AND WELFARE STANDARD CERTIFICATE OF DEATH

-61-040743

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1195

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

FILED DEC 11 1961

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CEDAR	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 9 DAYS	c. CITY OR TOWN STOCKTON Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BAPTIST HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) NORTH ST. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last KENT GILBERT LEONARD			4. DATE OF DEATH Month Day Year DEC. 3 1961		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/6/41	9. AGE (last birthday) 20	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY WALNUT CRACKER	11. BIRTHPLACE (City and state or country) EL DORADO SPRINGS, MO. USA	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME EZRA LEONARD	13b. MOTHER'S MAIDEN NAME NAOMI HOPKINS	14. NAME OF HUSBAND OR WIFE KAY LEONARD
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	17. INFORMANT Address EZRA LEONARD, STOCKTON, MO.
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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>Central Nervous System Tetanus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
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 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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 Springfield Mo	COUNTY CEDAR	STATE MO.
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21. I attended the deceased from <u>10/25/61</u> to <u>12/3/61</u> and last saw her/him alive on <u>12/3/61</u> . Death occurred at <u>12:48 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>T. E. Lohmeyer M.D.</u>	22b. ADDRESS <u>Springfield Mo</u>	22c. DATE SIGNED <u>12/4/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/6/61	23c. NAME OF CEMETERY OR CREMATORY ALDER CEMETERY	23d. LOCATION (City, town, or county) CEDAR COUNTY, MO.
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24. FUNERAL DIRECTOR H.H. LOHMEYER FUNERAL HOME ADDRESS SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 12-5-61	26. REGISTRAR'S SIGNATURE <u>Effie E. Mellan</u>
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DEC 19 1961

JAN 3 1962

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 H. A. McCann

Licensed Embalmer No. 2722

P. O. Address Spalding

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.