

MOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041577

MENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 96

FILED DEC 11 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)								
a. COUNTY <u>Lafayette</u>				a. STATE <u>Missouri</u> COUNTY <u>Lafayette</u>								
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Length of stay in lb <u>3 weeks</u>		c. CITY OR TOWN <u>Lexington</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>Lex. Memorial Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>South 3rd Street</u> <u>Lexington Twn.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)				4. DATE		Month		Day		Year		
<u>Leslie</u>				<u>November</u>		<u>25</u>		<u>1961</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>December 13, 1885</u>		9. AGE (last birthday) <u>75</u>		IF UNDER 1 YEAR		
										Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm OWNER</u>		11. BIRTHPLACE (City and state or country) <u>Mayview, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Thomas Jennings</u>				13b. MOTHER'S MAIDEN NAME <u>Ida Smitherman</u>				14. NAME OF HUSBAND OR WIFE <u>Betty Blevins</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>						17. INFORMANT <u>Mrs. Betty Jennings</u> Address <u>Lexington, Mo.</u>						
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) <u>Carcinoma of Prostate</u>										<u>unknown</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				
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.)								
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			COUNTY		STATE	
21. I attended the deceased from <u>10-23-61</u> to <u>11-25-61</u> and last saw her/him alive on <u>11-25-61</u> Death occurred at <u>1:04 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <u>Doc W Ward</u> (Degree or title)						22b. ADDRESS <u>Lexington Mo</u>			22c. DATE SIGNED <u>10-27-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>11-27-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Machpelah Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Lexington, Missouri</u>				
24. FUNERAL DIRECTOR <u>Vaughn-walker</u> ADDRESS <u>Lexington, Missouri</u>						25. DATE RECD. BY LOCAL REG. <u>11-27-61</u>		26. REGISTRAR'S SIGNATURE <u>M. E. Eastbrook</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 W. R. Vaughn
Licensed Embalmer No. 4023
P. O. Address Lexington

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.