

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-039181

STATE FILE NUMBER

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 200

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 9 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Jasper</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jasper</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webb City</b>		Length of stay in 1b <b>4 days</b>	c. CITY OR TOWN <b>Rural</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jane Ghinn Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rt. 1 Oronogo</b>
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Marie</b> Last <b>Leggett</b>		4. DATE OF DEATH Month <b>November</b> Day <b>3</b> , Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-3-1921</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>41</b>
11a. FATHER'S NAME <b>E.W. Olson</b>		11b. MOTHER'S MAIDEN NAME <b>Martha Gilchrist</b>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		12b. SOCIAL SECURITY NO.	
13a. FATHER'S NAME <b>E.W. Olson</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Gilchrist</b>	
14. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b>		14. NAME OF HUSBAND OR WIFE <b>Lloyd Leggett</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>pleural effusion</b>		15. BIRTHPLACE (City and state or country) <b>Rt. 1 Oronogo, Mo.</b>	
DUE TO (c) <b>Metastatic carcinoma</b>		16. CITIZEN OF WHAT COUNTRY <b>USA</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Carcinoma left breast</b>		17. INFORMANT <b>Lloyd Leggett, Rt. 1 Oronogo, Mo.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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 <b>5-15-62</b> to <b>11-3-62</b> and last saw her <u>him</u> alive on <b>11-3-62</b>		21. DEATH OCCURRED AT <b>6:19 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>E. A. Kelly, D.O.</b>		22b. ADDRESS <b>627 N. Broadway, Webb City, Mo.</b>	
22c. DATE SIGNED <b>11-5-62</b>		22d. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill Cemetery</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-5-62</b>	
23c. LOCATION (City, town, or county) <b>N.W. of Webb City, Mo.</b>		23d. STATE <b>Mo.</b>	
24. FUNERAL DIRECTOR <b>Johnston-Simpson, Webb City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-5-62</b>	
26. REGISTRAR'S SIGNATURE <b>Mrs. Madeline Switzer</b>			

NOV 16 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 Jack C. Simpson

Licensed Embalmer No. 4647

P. O. Address Webb City, Mo.

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.