

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-005870

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 100 Primary Registration District No. \_\_\_\_\_ Registrar's No. 25

STATE FILE NUMBER

**FILED MAR 11 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

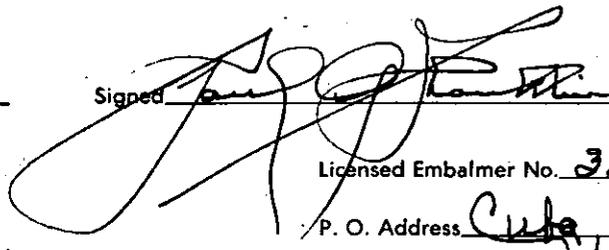
1. PLACE OF DEATH a. COUNTY <u>DENT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> , b. COUNTY <u>DENT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SALEM</u> Length of stay in 1b _____		c. CITY OR TOWN <u>SALEM</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>KNOX NURSING HOME</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>KNOX NURSING HOME</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEONN</u> <u>LEA</u>			4. DATE OF DEATH Month Day Year <u>March 8 1963</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>O.A. PENSIONER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (last birthday) <u>89</u>
11. BIRTHPLACE (City and state or country) <u>Steelville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George W. Cox</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Richards</u>	
14. NAME OF HUSBAND OR WIFE <u>John L. Lea - deceased</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>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>The deceased in arrangement for funeral</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Natural causes</u> DUE TO (b) <u>Senility</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none</u>			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 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. _____		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>1959</u> to <u>March 8, 1963</u> and last saw her <sup>him</sup> alive on <u>March 8, 1963</u> Death occurred at <u>8, M, m</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph R. Bennett D.O.</u>		22b. ADDRESS <u>Salem, Missouri</u>	
22c. DATE SIGNED <u>3-6-63</u>		22d. LOCATION (City, town, or county) (State) <u>Wearsburg, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>3-8-1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lea Cemetery</u>		23d. LOCATION (City, town, or county) <u>Wearsburg, Mo.</u>	
24. FUNERAL DIRECTOR <u>Paul J. Franklin, Cuba, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-8-63</u>	
26. REGISTRAR'S SIGNATURE <u>M. J. Hart, M.D.</u>			

(Licensed Embalmer's Statement on Reverse Side)

**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  \_\_\_\_\_  
Licensed Embalmer No. 3472  
P. O. Address Cuba, 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.