

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0005339

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 218 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

MR FILED 02 64

VS 300  
Rev. 4/59

15110

25110

3

4 0

5 1

6

7 0

8 2

9 4201

10

11

12 90-3

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marion Twp.</b>		Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>Easton</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Route 1 Easton, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Route 1</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LEONARD</b> Middle <b>ALBERT</b> Last <b>WALLER</b>			4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1964</b>
5. SEX <b>Male</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>5-26-1890</b>
9. AGE (last birthday) <b>73</b>		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) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Buchanan Co., Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>Albert Waller</b>	
13b. MOTHER'S MAIDEN NAME <b>Rosa Beck</b>		14. NAME OF HUSBAND OR WIFE <b>Lena</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>486-40-6153</b>	17. INFORMANT <b>Mrs Lena Waller R 1 Easton, Mo.</b> Address
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>Myocardial infarction</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>Breathing cold air could be</u> 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>a contributing cause</u>			INTERVAL BETWEEN ONSET AND DEATH <u>alone</u>
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.) <u>chest together eggs wife saw them fall</u>	
20c. TIME OF INJURY <b>3:30 p.m.</b>	Hour Month, Day, Year <b>2 25 64</b>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Easton R. 1, Buchanan Mo.</u>		
21. I attended the deceased from <u>viewed body</u> and last saw him <u>live</u> on <u>2-25-64</u> Death occurred at <u>3:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>2-26-64</u>	
22a. SIGNATURE (Degree or title) <u>S.E. Melaney M.D. Coroner</u>		22b. ADDRESS <u>2-214 Kirkpatrick Rd.</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 28, 1964</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hurlingen, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>H. O. Sidenfaden &amp; Son St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Feb. 26, 1964</b>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 2-26-64

**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 Robert H. Gage  
Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.