

Health,
& Welfare
Public
Health Service

V. S. 300
ev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 0 17 923
STATE FILE NUMBER
Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 188

FILED MAY 24 1957

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>LOUISIANA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LEVERING HOSP</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>1200 IOWA ST</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LEONARD OLEY ELLIOTT</u> First Middle Last			4. DATE OF DEATH <u>MAY 13, 1957</u> Month Day Year
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>AUG 24, 1921</u>
9. AGE (In years Last birthday) <u>35</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>	11. BIRTHPLACE (City and state or country) <u>LOUISIANA, MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>JOHN ELLIOTT</u>	13b. MOTHER'S MAIDEN NAME <u>ANNA L. EDDINGTON</u>	14. NAME OF HUSBAND OR WIFE <u>KATHERINE MARIE ELLIOTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u>	16. SOCIAL SECURITY NO. <u>48-7-18-0058</u>	17. INFORMANT Address <u>LOUISIANA, MISSOURI</u> <u>KATHERINE M. ELLIOTT</u>	
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>Crushed chest, injury to heart & lungs</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Crushed chest</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Crushed mandible & Maxilla, fracture rt arm, left leg.</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" 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>Pt. driving north, ran off of road, shoulder soft, came on again & struck south bound truck in south bound lane</u>		
20c. TIME OF INJURY Hour . Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>Highway 61</u>	20f. CITY, TOWN, OR LOCATION <u>Hannibal</u>	COUNTY <u>Marion</u>	STATE <u>Mo</u>
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Henry Severts JMD</u> (Degree or title) <u>Coroner</u>	22b. ADDRESS <u>1506 Market St Hannibal Mo</u>	22c. DATE SIGNED <u>5/17/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAY 14, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>LOUISIANA, MISSOURI</u>
24. FUNERAL DIRECTOR <u>GEO. M. COLLIER, LOUISIANA, MO</u>	25. DATE RECD. BY LOCAL REG. <u>5-18-57</u>	26. REGISTRAR'S SIGNATURE <u>Dr. Em. Lucke By W. Fisher</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

39

RECEIVED MAY 23 1957
MARION CO. HEALTH DEPT.
DATE FILED MAY 23 1957

MAY 24 1957

MAY 29 1957

MAY 29 1957

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 *Geo. M. Collier*

Licensed Embalmer No. *3839*
P. O. Address *Louisiana, 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.