

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035353  
STATE FILE NUMBER

FILED NOV 5 1958 Registration District No. 4 Primary Registration District No. 5025 Registrar's No. 87

1. PLACE OF DEATH a. COUNTY <b>Atchison</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Atchison</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural (Templeton Twp)</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Rock Port.</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>none</b> Length of stay in lb <b>X</b>		d. STREET (If outside, give location) ADDRESS <b>003 none</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harmon William Leseberg</b>			4. DATE OF DEATH Month Day Year <b>10 29 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-28-1890</b>
9. AGE (In years last birthday) <b>68</b> IF UNDER 1 YEAR Months <b>9</b> Days <b>1</b> IF UNDER 24 HRS. Hours <b>1</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (City and state or country) <b>Langdon, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>US</b>
13a. FATHER'S NAME <b>Frederick Leseberg</b>		13b. MOTHER'S MAIDEN NAME <b>Marie Majors</b>	
14. NAME OF HUSBAND OR WIFE <b>none</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>	
16. SOCIAL SECURITY NO. <b>485-03-3313</b>		17. INFORMANT Address <b>Otto Leseberg, Watson, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FRACTURED SKULL-CRUSHED CHEST</b>			INTERVAL BETWEEN ONSET AND DEATH <b>91213</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
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.) <b>TRACTOR RAN OVER HIM IN CORN FIELD</b>	
20c. TIME OF INJURY Hour Month, Day, Year <b>7:00 10 29 58</b>		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.) <b>FARM</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>003 Templeton Twp. Atchison, Mo.</b>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>D. W. Gallup, Coroner 3</b>		22b. ADDRESS <b>Rock Port, Mo.</b>	
22c. DATE SIGNED <b>10-29-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-31-1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hunter Cemetery.</b>		23d. LOCATION (City, town, or country) (State) <b>Rock Port, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Bartholomew Mortuary, Rockport.</b>		25. DATE RECD. BY LOCAL REG. <b>Oct 30, 1958</b>	
		26. REGISTRAR'S SIGNATURE <b>Merwin H. Schaefer</b>	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Geoff Bartsch* .....

Licensed Embalmer No. 3173 .....

P. O. Address Rock Port 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.