

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020297

STATE FILE NUMBER

56

FILED JUN 16 1959

Registration District No. 4 Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Atchison</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Holt</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fairfax</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Maitland</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Atchison Community Hosp 4</b>		Length of stay in lb <b>4</b> das	d. STREET ADDRESS <b>0440</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>LEAMAN LE ROY ESTES</b>			4. DATE OF DEATH Month Day Year <b>June 8, 1959</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>May 2, 1923</b>	9. AGE (In years at birthday) <b>36</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Depot agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>agent-Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Hopkins, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Ancil L. Estes</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Pauline Olmstead</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs Louise A. Estes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) (If yes, give war or dates of service) <b>Yes II</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT Address <b>Mrs Louise A. Estes, Maitland, 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>Terminal Uremia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <b>Kimmelsteil Wilson Disease</b>					<b>Unknown</b>
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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>July 1, 1958</b> to <b>June 8, 1959</b> and last saw him alive on <b>June 8, 1959</b> Death occurred at <b>8 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Isaac F. Sweeney M.D.</b>			22b. ADDRESS <b>Atchison, Mo</b>		22c. DATE SIGNED <b>6/18/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/11, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maitland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Maitland, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Atchison, Mo</b>			25. DATE RECD. BY LOCAL REG. <b>June 11, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Thermin H. Sealer</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Securing the medical certification in the specific manner required by 193.140 MoRS 1949. 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.

JUN 19 1959

JUL 7 1959

SEP 29 1959

JUN 24 1959

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 *G M Althouse*

Licensed Embalmer No. *2379*

P. O. Address *Marshall*

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.