

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-027844

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 273

FILED AUG 6 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Marion.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal, Missouri.		Length of stay in 1b 90Days	c. CITY OR TOWN Kansas City, Missouri Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Shadey Lawn Lodge		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1220 E. Armer St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last LEONA MARTHA FISHBACK.			4. DATE OF DEATH Month Day Year July 26, 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-16-70
9. AGE (last birthday) 92		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework.		10b. KIND OF BUSINESS OR INDUSTRY Home work.	11. BIRTHPLACE (City and state or country) Derby, Iowa.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Samuel L. McBurney. 13b. MOTHER'S MAIDEN NAME Mary Virginia Leech. 14. NAME OF HUSBAND OR WIFE John Wm Fishback.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Miss Georgia Fishback. K.C., Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident progressive DUE TO (b) Arteriosclerotic heart disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 4 months 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
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>4-20-62</u> to <u>7-26-62</u> and last saw her/him alive on <u>7/25/62</u> . Death occurred at <u>3:50</u> <u>A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert J. Lanning, Jr. M.D.</i> (Degree or title)		22b. ADDRESS Hannibal, Missouri.	22c. DATE SIGNED 7-26-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-28-1962	23c. NAME OF CEMETERY OR CREMATORY Odessa Cemetery.	23d. LOCATION (City, town, or county) (State) Odessa, Missouri.
24. FUNERAL DIRECTOR ADDRESS <i>Clyde S. Wisbey, Perry, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>July 30, 1962</i>	26. REGISTRAR'S SIGNATURE <i>Dr. E. M. Leach By Lillian M. Herman</i>

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 *D. E. Perry*

Licensed Embalmer No. 3820.

P. O. Address Perry, Missouri.

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.

Permit received 7/30/62