

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-045341

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3299

FILED DEC 7 1962

VS 300
Rev. 4/59

1 4002
2 0640
3 2
4 1
5 2
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7 0
8 2
9 783.2
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11
12 92-3
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		Length of stay in 1b DOA	c. CITY OR TOWN Hannibal Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 404 Center St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Katherine Middle M. Last Leonard			4. DATE OF DEATH Month November Day 11 Year 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 11/11/1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (last birthday) 83 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) Hannibal, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Benjamin Eales		13b. MOTHER'S MAIDEN NAME Sarah Parker	
14. NAME OF HUSBAND OR WIFE Archibald Leonard		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 Sterrett Smith, #5 Berrywood Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown natural causes Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) (Christian Scientist - no medical treatment; however, history of shortness of breath and ankle swelling) DUE TO (c) _____ 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			INTERVAL BETWEEN ONSET AND DEATH
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 _____ Month _____ Day _____ Year _____ 6:30 PM 11-12-62			
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 _____, to _____ and last saw her/him alive on _____ Death occurred at approx. 6:30 PM _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>James Ward</i>		22b. ADDRESS Coroner Clayton, Missouri	
22c. DATE SIGNED 11/15/62		23. NAME OF CEMETERY OR CREMATORY	
23a. BURIAL OR REMOVAL (Specify) Removal		23b. DATE 11-12-62	
24. FUNERAL DIRECTOR Smith Funeral Home, Hannibal, Mo.		25. DATE RECD. BY LOCAL REG. 11-12-62	
26. REGISTRAR'S SIGNATURE <i>John B. Murphy, M.D.</i>		23d. LOCATION (City, town, or county) Hannibal, Mo. (State)	

USE BLACK INK OR TYPEWRITER RIBBON

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

Harvey Kahl

Licensed Embalmer No. 4596

P. O. Address St Louis, 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.