

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 13385 Primary Registration District No. _____ Registrar's No. 0051001 STATE FILE NUMBER.

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 1010
2 1010
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4 0
5 1
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12 90-2
13 1-0

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 <u>Shannon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Shannon</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	c. CITY OR TOWN <u>Mountain View</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Albert Seland Leonard</u>			4. DATE OF DEATH Month Day Year <u>December 28 1964</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>12/24/18</u>	9. AGE (last birthday) <u>46</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & Ins. Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Mtn. View, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>William J. Leonard</u>		13b. MOTHER'S MAIDEN NAME <u>Willie G. Willbanks</u>		14. NAME OF HUSBAND OR WIFE <u>Lucille M. Leonard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or days of service) <u>yes W.W. # 2</u>		16. SOCIAL SECURITY NO. <u>497-12-9725</u>	17. INFORMANT Address <u>Lucille M. Leonard Mtn. View, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u>					<u>5 minutes</u>
DUE TO (b) <u>Lobar Pneumonia</u>					<u>1 week</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)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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>Dec 23, 1964</u> to <u>Dec 27, 1964</u> and last saw her/him alive on <u>Dec 27, 1964</u> Death occurred at <u>2:15 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Stanley Barnum D.O.</u>			22b. ADDRESS <u>Mountain View, Mo</u>		22c. DATE SIGNED <u>1-6-65</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/31/64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Mtn. View, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Duncan Funeral Home Mtn. View, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-9-1965</u>	26. REGISTRAR'S SIGNATURE <u>Mabel Rolland per Ann Selvey</u>		

USE BLACK INK OR TYPEWRITER RIBBON

To Dr. 12/29/64
Rec'd from Dr. 1/9/65
To Loc. Reg. 1/9/65

Permit Obtained

STATEMENT BY LICENSED EMBALMER

FEB 5 1965

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 Charles D. Partain

Licensed Embalmer No. 5107

P. O. Address Mt. View, 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.