DEPARTMENT OF PUBLIC HEALTH AND WELFARE — MISSOURI DIVISION OF HEALTH

FILED MAY 12 1969

(PHYSICIAN OR CORONER)

XX

CERTIFICATE OF DEATH

124

STATE FILE NUMBER 69-014921

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 291

DO NOT WRITE ON THIS STUB

9. 1
10a. 80
10b.
11. 0
12. 2
13. 2699
14.
15. 4
16. - -
17. ~~0~~ 4
18. 2
19. CREDITS
20. 1 - 1

VS 300
Rev. 1/68

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5. 01

DECEASED

1. DECEASED—NAME: Mary Christine Leimer
2. SEX: Female
3. DATE OF DEATH (MONTH, DAY, YEAR): April 25, 1969
4. RACE (WHITE, NEGRO, AMERICAN INDIAN, ETC.) (SPECIFY): White
5a. AGE—LAST BIRTHDAY (YEARS): 80
5b. UNDER 1 YEAR: MOS / DAYS
5c. UNDER 1 DAY: HOURS / MIN.
6. DATE OF BIRTH (MONTH, DAY, YEAR): January 13, 1889
7a. COUNTY OF DEATH: Cape Girardeau
7b. CITY, TOWN, OR LOCATION OF DEATH: Cape Girardeau
7c. INSIDE CITY LIMITS (SPECIFY YES OR NO): Yes
7d. HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER): Osteopathic Hospital
8. STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY): Missouri
9. CITIZEN OF WHAT COUNTRY: USA
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY): Widowed
11. SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME):
12. SOCIAL SECURITY NUMBER: None
13a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED): Housekeeping
13b. KIND OF BUSINESS OR INDUSTRY: retired

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

60160

14a. RESIDENCE—STATE: Missouri
14b. COUNTY: Cape Girardeau
14c. CITY, TOWN, OR LOCATION: Fruitland
14d. INSIDE CITY LIMITS (SPECIFY YES OR NO): Yes
14e. STREET AND NUMBER: Rt. 1, Jackson, Missouri

PARENTS

15. FATHER—NAME: Edward Gross
16. MOTHER—MAIDEN NAME: Elizabeth Wallman

17a. INFORMANT—NAME: Gilbert Leimer
17b. MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): Rt. 1, Jackson, Missouri 63755

CAUSE

PART I. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))

18. IMMEDIATE CAUSE
(a) Pulmonary edema — 24 hours
DUE TO, OR AS A CONSEQUENCE OF:
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST
(b) Congestive heart failure — 15 days
DUE TO, OR AS A CONSEQUENCE OF:
(c) Inanition and debilitation

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a): Open reduction of left femur

19a. AUTOPSY (YES OR NO): No
19b. IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH

20a. ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY): Accident
20b. DATE OF INJURY (MONTH, DAY, YEAR): 4/11/1969
20c. HOUR: P.M.
20d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18): Fell in her home fracturing hip.
20e. INJURY AT WORK (SPECIFY YES OR NO): No
20f. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY): Home
20g. LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE): Route #1, Jackson, Missouri

CERTIFIER

21a. CERTIFICATION—PHYSICIAN: I ATTENDED THE DECEASED FROM April 11, 1969 (MONTH DAY YEAR) TO 21b. April 25, 1969 (MONTH DAY YEAR)
21c. AND LAST SAW HIM/HER ALIVE ON April 25, 1969 (MONTH DAY YEAR)
21d. I DID/DID NOT VIEW THE BODY AFTER DEATH: did
21e. DEATH OCCURRED (HOUR): 10:40 a.m. AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED.

22a. CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED. HOUR OF DEATH: 10:40 A.M.
22b. THE DECEDENT WAS PRONOUNCED DEAD: MONTH April DAY 25, YEAR 1969 HOUR 10:40 A.M.

23a. CERTIFIER—NAME (TYPE OR PRINT): Walter W. Hutton, D.O.
23b. SIGNATURE: Walter W. Hutton D.O. DEGREE OR TITLE
23c. DATE SIGNED (MONTH, DAY, YEAR): 5-8-69
23d. MAILING ADDRESS—CERTIFIER: 104 E. Washington Avenue, Jackson, Missouri 63755 (STREET OR R.F.D. NO. / CITY OR TOWN / STATE / ZIP)

BURIAL

24a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
24b. CEMETERY OR CREMATORY—NAME: St. Johns Cemetery
24c. LOCATION (CITY OR TOWN, STATE): Pocahontas, Missouri
24d. DATE (MONTH, DAY, YEAR): April 27, 1969
25a. FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): McCombs Funeral Home, Jackson, Missouri 63755
25b. FUNERAL DIRECTOR—SIGNATURE:
26a. REGISTRAR—SIGNATURE: L. M. Garner, M.D.
26b. DATE RECEIVED BY LOCAL REGISTRAR: May 12, 1969

Type or print in PERMANENT BLACK INK. See handbook for instructions.

JUN 6 - 1969

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_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.