LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

22347

V. S. No. 2. A

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

2347

1 PLACE OF DEATH

nty Jasper

nship

ge Webb City

Jasper Co Tubercular Hospital (No. St.; Ward)

2 FULL NAME James Madison Leonard

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 417 File No. 126

Primary Registration District No. 304 Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
ll	White	Single

E OF BIRTH Oct (Month) 8 (Day) 1874 (Year)

45 yrs. 9 mos. 7 ds. If LESS than 1 day, ... hrs. or ... min.?

UPATION Trade, profession, or icular kind of work Stationary Engineer

General nature of industry ness or establishment in h employed (or employer)

THPLACE or town, or foreign country) Tenn.

10 NAME OF FATHER J. E. Leonard

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn

12 MAIDEN NAME OF MOTHER Elizabeth Driden

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

formant) Mrs Elizabeth Driden Row

(Address) Joplin Mo

ed June 15th 1920 J. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 15 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 28, 1920, to June 15, 1920, that I last saw him alive on June 14, 1920, and that death occurred, on the date stated above, at 1:30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic pulmonary tuberculosis

23 A 28

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Varney Hazlewood M. D.

June 15, 1920. (Address) Webb City T.B. Hospital

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 1 yrs. 10 mos. 14 ds. In the State 30 yrs. mos. ds.

Where was disease contracted if not at place of death? Lead and zinc mines.

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mound cemetary

DATE OF BURIAL June 17, 1920

20 UNDERTAKER Frank Sievers and Co

ADDRESS Joplin Mo.

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V.S. No. 2. A

1 PLACE OF DEATH

County .....

Township..... Registration District No..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO....., ...St.;.....Ward)

MISSOURI STATE BOARD OF HEA
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

[If death occu
hospital or in
give its NAME
of street and n

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) (Day), 1..... (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) (Day), 191

17 I HEREBY CERTIFY, that I attended deceased

....., 191....., to....., 19

that I last saw h.....alive on....., 19

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....

CONTRIBUTORY .....
(Secondary)

..... (Duration)..... yrs.....mos.....

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Caus
(1) Means of Injury; and (2) whether Accidental, Suicidal or Hom

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran
or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 1

20 UNDERTAKER | ADDRESS