

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

1. PLACE OF DEATH

County St. Louis Registration District No. 908 File No. 23337
 Township Mountain Grove Primary Registration District No. 14549 Registered No. 288
 City Mountain Grove (No.) St. Ward)

2. FULL NAME Henry Lewis Leach

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Mary A. Beasley
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 3 - 46
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
77 | 6 | 20
 8. OCCUPATION OF DECEASED farmer
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
 (STATE OR COUNTY) Gasconade Co. Mo.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
 (STATE OR COUNTRY)

14. Mr. H. L. Leach
 (Address) Mountain Grove Mo.

15. FILED 8/1 19 28 M. Hubbard
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 26 - 1923

17. I HEREBY CERTIFY, That I attended deceased from July 20
1923, 19 23 to July 26 19 23
 that I last saw him alive on 7/26, 19 23 and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile atrophy of quadriceps
of foot & leg. Amputation of leg.
 (duration) yrs. mos. ds.
 CONTRIBUTORY Broncho Pneumonia
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? no
 DID AN OPERATION PRECEDE DEATH? no DATE OF July 24 19 23

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) J. P. Hall M.D.
7/26 1923 (Address) Mountain Grove

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
City Hall July 27 19 23
Brinkley Co.

20. UNDERTAKER ADDRESS
A. P. Botter Mountain Grove

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.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles: Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

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

1. PLACE OF DEATH

County.....

Registration District No. 908

File No.

Township.....

Primary Registration District No. 45-49Registered No. 288

City.....

(No.)

St.

Ward)

2. FULL NAME

(a) Residence. No.

St.

Ward

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

OR LESS than 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED..... 19.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/23 19 23

17.

I HEREBY CERTIFY, That I attended deceased from 19....., to July 23, 19.....that I last saw him alive 7/20, 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

HAD AN OPERATION PRECEDING DEATH

DATE OF

WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed).....

19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

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M

PARENTS

*This is to report a death
seen today August 17
at home of deceased
as certified by
Dr. J. H. ...*

*Heart failure
due to aortic
stenosis
and
hypertension
with
coronary
arteriosclerosis
and
myocardial
infarction
of the
anterior
wall
of the
left
ventricle
with
conduction
system
disease
and
pericarditis
with
effusion
and
adhesions
of the
pericardium
to the
anterior
wall
of the
heart
with
compression
of the
heart
and
obstruction
of the
coronary
arteries
with
myocardial
infarction
of the
anterior
wall
of the
left
ventricle
with
conduction
system
disease
and
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with
effusion
and
adhesions
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pericardium
to the
anterior
wall
of the
heart
with
compression
of the
heart
and
obstruction
of the
coronary
arteries*

N. B.
CAUSE

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health
Association.)

23327

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