JUL 26 1927

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

Dr Wilbur Smith

Do not use this space.

18023

1. PLACE OF DEATH
County Greene — Registration District No. 318 — File No.
Township — Primary Registration District No. 2001 — Registered No. 371
City Springfield (No. Spr Baptist Hospital St. Ward)

2. FULL NAME Mrs Bettie Leavitt
(a) Residence. No. Houston Mo. 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 F
4. COLOR OR RACE Wh.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 12. 1851

7. AGE Years 76 Months Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) " "
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lick Springs
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER Samuel Hyer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dont Know.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT Oscar B Leavitt
(Address) Houston Mo.

15. FILED 6/16 1927 O C Horst MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/15 1927

17. I HEREBY CERTIFY, That I attended deceased from 6/11, 1927, to 6/15, 1927 that I last saw her alive on 6/14 1927 and that death occurred, on the date stated above, at 12:10 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
2 10M Pneumonia
109A
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Contusion of Brain
4 internal injuries
(duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Houston. Mo
DID AN OPERATION PRECEDE DEATH? yes DATE OF 6/11/27
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Wilbur Smith, M. D
6/15, 1927 (Address) Springfield Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Houston. Mo — DATE OF BURIAL June 16 1927

20. UNDERTAKER Alma Lohmeyer. Spr. Mo. — ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A ...

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Greene Registration District No. 318 File No.
Township Primary Registration District No. 2001 Registered No. 371
City Springfield (No. St. Ward)

2. FULL NAME Mrs. Bettie Leavell
(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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

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)

PARENTS
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 6/16, 1927 O C Horst Mbr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 15 1927

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Contusion of Brain and internal injuries
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Automobile accident at
IF NOT AT PLACE OF DEATH? Houston Mo.
DID AN OPERATION PRECEDE DEATH? Texas County
DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 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.

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

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

...E PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

S-18023