

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

Do not use this space.

PLACE OF DEATH

County Greene

Registration District No. 318

File No. 26947

Township Springfield

Primary Registration District No. 2001

Registered No. 548

City Springfield

(No. _____)

St. _____

Ward _____

2. FULL NAME Lenard M Lisenby

(a) Residence No. 1519 West Elm St. _____ Ward _____

(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

MEDICAL CERTIFICATE OF DEATH

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 or (OR) WIFE OF

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

April 2nd 185

7. AGE

75

YEARS

MONTHS

5

DAYS

4

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

8. OCCUPATION OF DECEASED

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

(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)

Ill

10. NAME OF FATHER

Andrew Lisenby

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill

12. MAIDEN NAME OF MOTHER

Sufurina Lingle

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill

14. INFORMANT

(Address)

Mrs M Lisenby
1519 West Elm

15. FILED

_____ 19

9/10 27 October

REGISTRAR

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

Sept 6 19 27

17.

I HEREBY CERTIFY, That I attended deceased during past 5 or 6 yrs from Sept 6 19 27 to Sept 6 19 27 that I last saw her alive on Sept 6 19 27, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

71A

936 5 mo (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Angina Pectoris had the attack at 10-AM last at 1 PM (duration) yrs. mos. ds.

death in a few minutes

18. WHERE DISEASE CONTRACTED

IF NOT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____

A. Stehkins, M. D.

, 19

(Address) 318 College St

*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

Maple Glen CEMETERY

9/8 19 27

20. UNDERTAKER

ADDRESS

W. J. P. Meyer

Springfield

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important.

