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

**1 PLACE OF DEATH**

County: Newton

Township: ..... Registration District No. 614 File No. 31059

or

Village: ..... Primary Registration District No. 4555 Registered No. 40

or

City: Granby (NO. ....., St. 2 Ward)

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

**2 FULL NAME** John Nelson Leamon

**PERSONAL AND STATISTICAL PARTICULARS**

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | White | Married |

**6 DATE OF BIRTH** Sept. (Month) 8 (Day) 1853 (Year)

**7 AGE** 74 yrs. 1 mos. 1 ds. — If LESS than 1 day, ..... hrs. or ..... min.?

**8 OCCUPATION**
(a) Trade, profession, or particular kind of work: None Invalid 18 yrs
(b) General nature of industry business, or establishment in which employed (or employer): None

**9 BIRTHPLACE** (City or town, State or foreign country): Illinois

**PARENTS**

10 NAME OF FATHER: Benjamin Leamon

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

12 MAIDEN NAME OF MOTHER: Nancy Harris

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

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Andrew Leamon

(Address) Granby Mo

**15** Filed 10-10 ..... 19..... M. H. Lurlum Registrar

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** Oct. (Month) 9 (Day) 1927 (Year)

**17** I HEREBY CERTIFY, that I attended deceased from Sept. 15 1927 to Oct. 9 1927 that I last saw him alive on Sept. 15 1927 and that death occurred, on the date stated above, at 9:40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Diarrhea
Probably Tubercular
25
12-0 B about (Duration) 18 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
0 (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Langley M. D.

Oct. 10 1927 (Address) Granby Mo

*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 ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

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

Former or usual residence .....

**19 PLACE OF BURIAL OR REMOVAL** Granby Cemetery Mo — DATE OF BURIAL 10/10 1927

**20 UNDERTAKER** F. J. Bigham — ADDRESS Neosho Mo

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County .....

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

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

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) ....., 1..... (Day) (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) ....., 191..... (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

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

that I last saw h.....alive on ....., 191.....,

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed) ..... M. D.

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

*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 .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ....., 191.....

20 UNDERTAKER

ADDRESS

# 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: Newton — Registration District No. 614 — File No.
Township — Primary Registration District No. 4555 — Registered No. 46
City: Granby (No. ..., ..... St. ..... Ward)

2. FULL NAME: Wm Nelson Leamon

(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: M
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 Dec 10 1927 H Lurwick
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 9 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:
Chronic Diarrhea
Probably tuberculous
Bowel
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) ...
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ...
DID AN OPERATION PRECEDE DEATH? ... DATE OF ...
WAS THERE AN AUTOPSY? ...
WHAT TEST CONFIRMED DIAGNOSIS? ...
(Signed) J. W. Langley, M. D.
Dec 10 1927 (Address) Granby 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 — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

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NOTE:—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THE BLANKS ARE FILLED IN, SIGNED AND PRESENTED BY LAW.

FOLD FOR BINDING

S-31059