

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

Do not use this space.

33297

1. PLACE OF DEATH

County Henry
Township Windsor
City Windsor (No. _____)

Registration District No. 14
Primary Registration District No. 4211

File No. _____
Registered No. 29
St. _____ Ward _____

2. FULL NAME

Le Count DeLacy Daniels

(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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 18 - 1848

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>79</u>	<u>11</u>	<u>5</u>	

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) New York

10. NAME OF FATHER

Le Roy Daniels

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) New York

12. MAIDEN NAME OF MOTHER

Farmstead

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) New York

14.

INFORMANT Mr. Robt. Jones
(Address) Windsor, Mo.

15. 10025 27
FILED _____ 19 27

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov-23 1927

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____ and that I last saw him alive on Nov 22, 1927, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS: _____

(Signed) J.A. Blackmore, M. D.

11-25-1927 (Address) Windsor, 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

Windsor Mo. Nov 25 1927

20. UNDERTAKER ADDRESS

A. E. Huston Windsor Mo.

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.

