

Aug 23 1928

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

Do not use this space.

1. PLACE OF DEATH

County Greene Registration District No. 325 File No. 23583  
Township Walnut Grove Primary Registration District No. 3420 Registered No. \_\_\_\_\_  
City Walnut Grove No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

David P. Leombo

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 \_\_\_\_\_

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
79 | 5 | 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) on farm near  
(STATE OR COUNTRY) Hard

10. NAME OF FATHER Sidney Leombo

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

12. MAIDEN NAME OF MOTHER Elizabeth Hammen

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

14. INFORMANT Conrad Leombo  
(Address) Springfield Mo

15. FILED 723 1928 H. M. Leombo  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/22/1928

17. I HEREBY CERTIFY, That I attended deceased from noon 1 \_\_\_\_\_, 1928, to noon 24 \_\_\_\_\_, 1928, that I last saw deceased alive on \_\_\_\_\_, 1928, and that death occurred, on the date stated above, at \_\_\_\_\_ 9 p \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Seriously

CONTRIBUTORY (SECONDARY) 164

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) L. E. McQuinn, M. D.

1928 (Address) Walnut 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER Green & Co July 23 1928  
ADDRESS Walnut Grove

Brown and Co



**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  
Township Walnut Grove  
City (No. ....) .....

Registration District No. 325-  
Primary Registration District No. 3450

File No. ....  
Registered No. ....  
St. .... Ward

2. FULL NAME

David R. Combs

(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) Feb 3 - 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
39 5 19

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 7-23, 1928 L. M. Cleburne  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/22 1928

17. I HEREBY CERTIFY, That I attended deceased from .....  
to ..... 19....., and that  
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:

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)....., 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

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

SUPPLEMENTARY

S-23583

11/11