

JAN 28 1928

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

Do not use this space.

43750

1. PLACE OF DEATH

County Saline
Township Saline
City Saline

Registration District No. 830
Primary Registration District No. 6091

File No. 40
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Lewis Griffin Leake
Furness Smith Hospital

Saline
(If nonresident give city or town and State)

(a) Residence No. _____ (Usual place of abode)
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) Mildred L. Leake

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-25-1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 1 18

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hammer
(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) Missouri

10. NAME OF FATHER Charles Leake

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

12. MAIDEN NAME OF MOTHER Luise Winston

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

14. INFORMANT (Address) Mrs. Guffin Leake
Saline Mo.

15. FILED 12/13/28 Miss Mary Gorch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-13 1928

17. I HEREBY CERTIFY, That I attended deceased from 12-11-28, 1928, to 12-13, 1928, that I last saw him/her alive on 12-13, 1928, and that death occurred, on the date stated above, at 4:15 a. m.

18. CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Rt L. & Hall of Left
1081
110 B (duration) yrs. mos. 2 da.

CONTRIBUTORY (secondary) Diaphragmatic Hernia (duration) yrs. mos. 2 da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

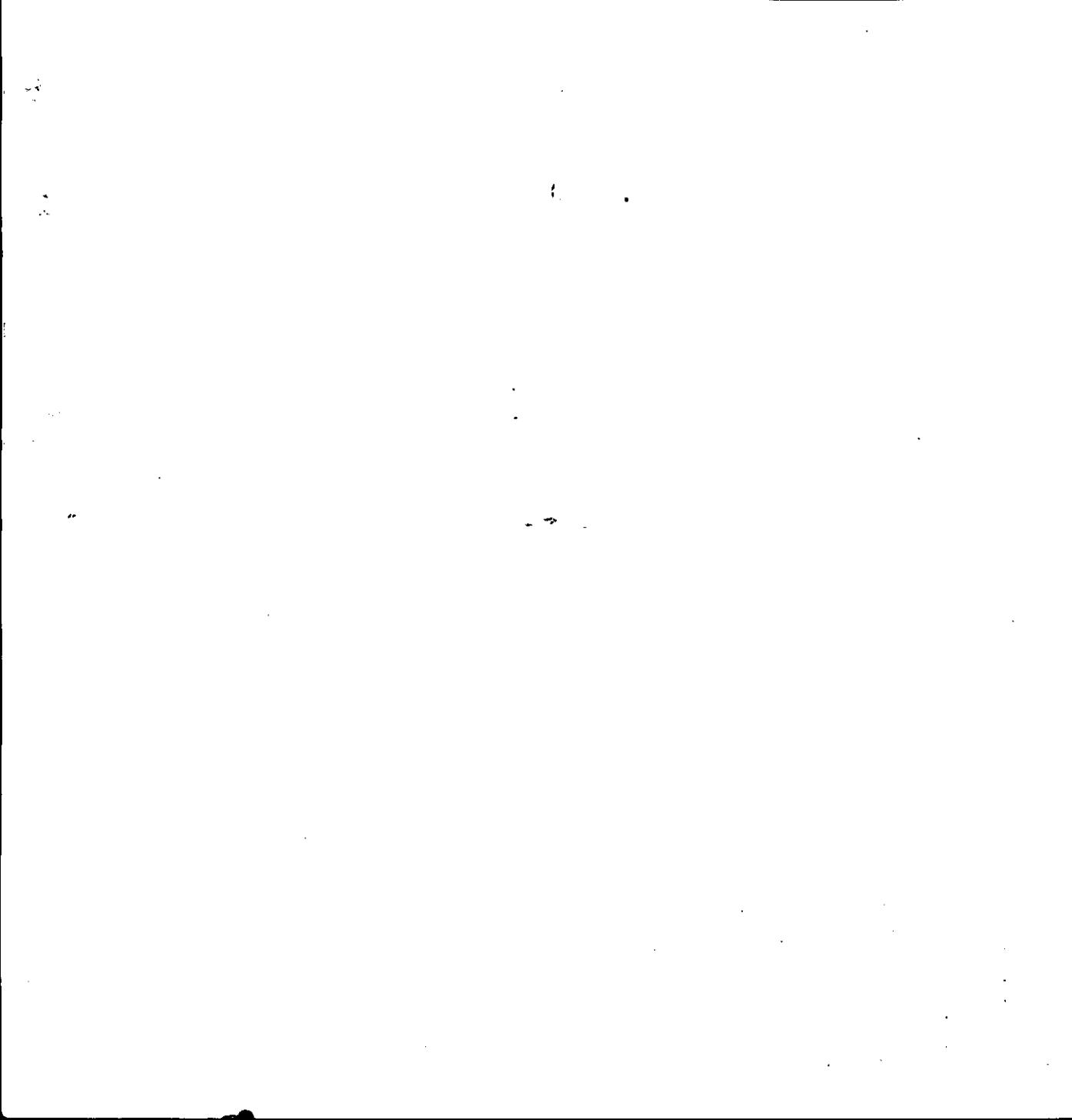
20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
a. m. Ward, M. D.
(Signed) _____, 19 (Address) Saline 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 900th Saline DATE OF BURIAL 12/15 1928

20. UNDERTAKER Boyer & Givan ADDRESS Saline Mo.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Shelby Registration District No. 830 File No. 40
 Township Salt River Primary Registration District No. 6091 Registered No.
 City St. Ward

2. FULL NAME

Lewis Griff Leake
 (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)

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 Jan 16, 1929 Widg. Gooch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-13-1928

17. I HEREBY CERTIFY That I attended deceased from 1928,
 that I last saw h. alive on , 1928, and that death occurred, on the date stated above at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia, right lung & tuberculosis left lobar

(duration) yrs. 3 mos. ds.
 CONTRIBUTORY (SECONDARY) 10/10 (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 28 (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 28

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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

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