

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

Do not use this space.

6905

1. PLACE OF DEATH

County JASPER Registration District No. 407
 Township _____ Primary Registration District No. 4241
 City CARTERVILLE (No. _____) St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME WILLIAM H. LEONARD

(a) Residence. No. 303 WALNUT 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 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 MARY LEONARD

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6/29/1855

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
73 7 21

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) DAYTON
 (STATE OR COUNTRY) OHIO

10. NAME OF FATHER WILLIAM LEONARD

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

12. MAIDEN NAME OF MOTHER SNIDER

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

14. INFORMANT MRS. MARY LEONARD
 (Address) CARTERVILLE, MO.

15. FILED 2-22-19 W. H. Gray REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/20/29 19

17. I HEREBY CERTIFY, That I attended deceased from _____
21.6 1929, to 27.20 1929
 that I last saw him alive on 27.20 1929, and that death occurred, on the date stated above, at 10:30 p. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Nephritis
118
130

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) L. K. Kitchell M. D.

7/25 1929 (Address) Webb City, 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

Mt Hope Cem. 2/23/29

20. UNDERTAKER'S ADDRESS
STEELE UNDERTAKING CO. WEBB CITY

95
25
1
73

1
15
2

225

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

ALL INFORMATION RELATED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Gasconade Registration District No. 404 File No. _____
 Township _____ Primary Registration District No. 4241 Registered No. _____
 City Carterville (No. _____) St. _____ Ward _____

2. FULL NAME William H. Leonard

(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 _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

m w 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 4-10-1929

W. H. Gray
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-20-29

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:

Acute Nephritis
 (duration) yrs. mos. ds. _____
 CONTRIBUTORY Acute attack of flue.
 (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

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

SUPPLEMENTARY

S-6905