MAY 29 1929.

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

Do not use this space.

15787

File No. 32

Registered No.

1. PLACE OF DEATH

County St Francois Registration District No. 774

Township St Francois Primary Registration District No. 4465

City Flat River (No. ..... St. ..... Ward)

2. FULL NAME Leroy Eden

(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: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Baby

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/16-1929

7. AGE: Years | Months | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Flat River
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Robert Eden

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Madison Co. Mo.

12. MAIDEN NAME OF MOTHER Lizzie Wampler

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Madison Co. Mo.

14. INFORMANT Robert Eden
(Address) Flat River Mo

15. FILED April 20, 1929 L. L. Heith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/17 1929

17. I HEREBY CERTIFY, That I attended deceased from 4/16, 1929, to 4-17-1929, that I last saw him alive on 4-17-1929, and that death occurred, on the date stated above, at 3-0 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Congenital weakness
158
..... (duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (SECONDARY) 160
..... (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. M. Fuson, M. D
4-17, 1929 (Address) Perryville 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: Madison Co. Mo. DATE OF BURIAL: 4-18 1929

20. UNDERTAKER: Raymond Caldwell ADDRESS: Elsinore

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.