

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

Do not use this space.

36821

**1. PLACE OF DEATH**

County Franklin  
Township Washington  
City Washington Mo. (No. ....)

Registration District No. 297  
Primary Registration District No. 3016

File No. ....  
Registered No. 100  
St. .... Ward)

**2. FULL NAME**

Elizabeth Mary Leif  
(a) Residence. No. 611 Roberts St., ..... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? yrs. .... mos. .... ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 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 Ben A. Leif

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 4 - 1877

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1	
				day, ..... hrs.	or ..... min.
	<u>51</u>	<u>11</u>	<u>9</u>		

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work House wife  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Peers, Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER John Glosemeyer

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

12. MAIDEN NAME OF MOTHER Mary Nambel

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

14. INFORMANT Ben Leif  
(Address) Washington

15. FILE NO. Nov. 15 1929 REGISTRAR O. L. Munich

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-13-29 19

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Nov 13, 1929, that I last saw her alive on Nov 13, 1929, and that death occurred, on the date stated above, at 5:15 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Parenchymatous nephritis  
131  
05B

(duration) 2 yrs. .... mos. .... ds.  
CONTRIBUTORY (SECONDARY) Acute Dilatation of Heart

(duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED? At home  
IF NOT AT PLACE OF DEATH. ....

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical  
(Signed) O. E. Meekoff M. D.  
11/14, 1929 (Address) Washington 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 Catholic Church DATE OF BURIAL 11/16/29

20. UNDERTAKER Neuberg & Vitt ADDRESS Washington Mo.

WRITE MAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

4/10/1929

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