

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

Do not use this space.

1627

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1. PLACE OF DEATH

County Jasper
Township Webb City
City Webb City (No.)

Registration District No. 417
Primary Registration District No. 3021

File No.
Registered No. 2
St. Ward)

2. FULL NAME Mrs. Mattie M. Leniton

(a) Residence. No. 1230 W. Broadway 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 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 F. C. Leniton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 4, 1895

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 11 4 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. at Home
(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) Kansas

10. NAME OF FATHER John Fields

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

12. MAIDEN NAME OF MOTHER Mamie Humphrey

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

14. INFORMANT F. C. Leniton
(Address) 1230 W. Broadway

15. FILED 18 19 30 R. M. Stormont
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 7 1930

17. I HEREBY CERTIFY, That I attended deceased from 12-18-1929 to 1-7-1930
that I last saw him alive on 1-7-1930 and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS Pentonytic Saporony, Dysuria, F. Cophony

1215 (duration) yrs. mos. ds.
1375
35A CONTRIBUTOR (SECONDARY) Almonc G. G. G. G. G. (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH? no DATE OF 14-1930

WAS THERE AN AUTOPSY? no

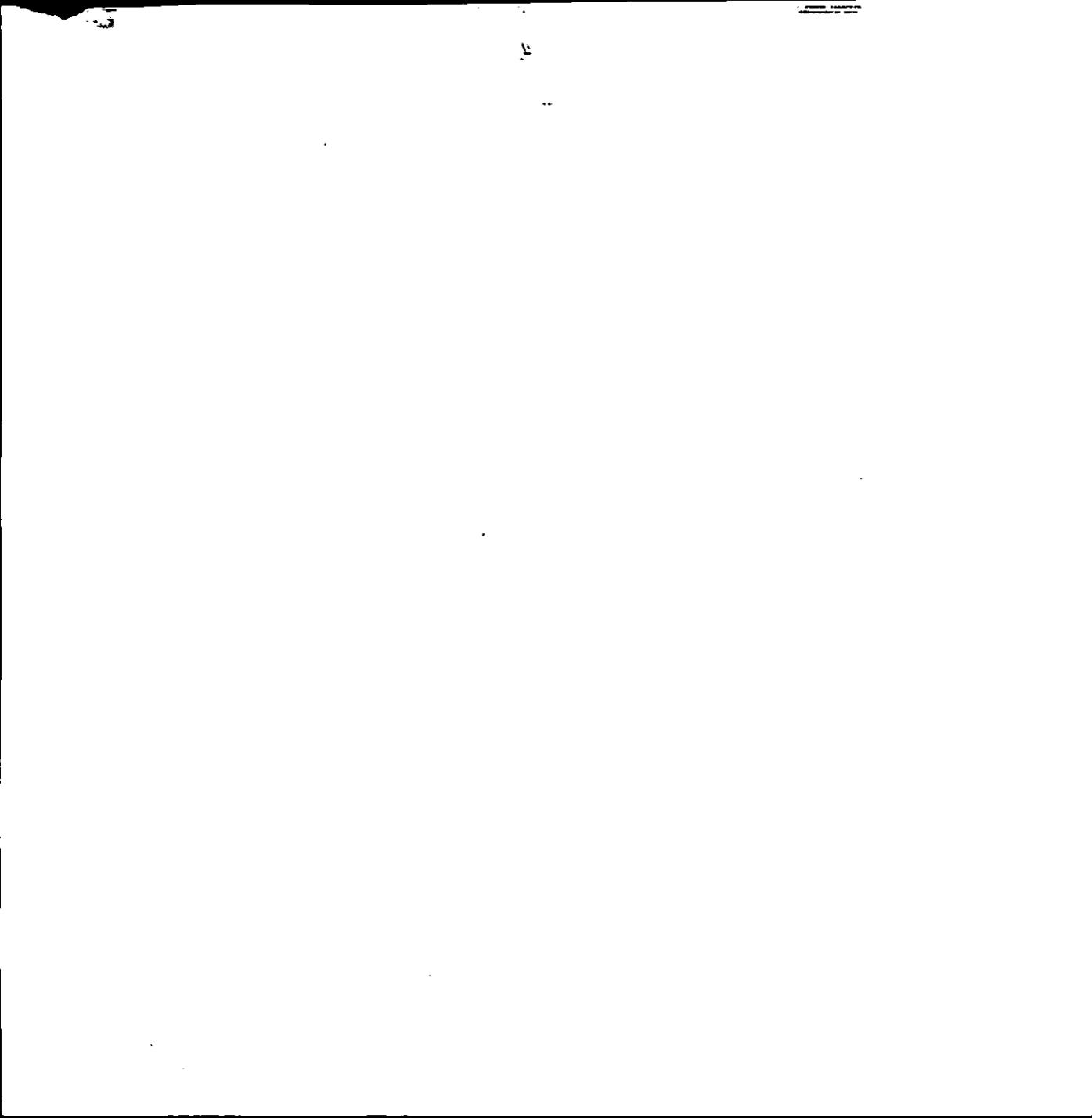
WHAT TEST CONFIRMED DIAGNOSIS? W. J. W. W. W. W.
(Signed) W. J. W. W. W. W. M. D.

18 19 30 (Address) Webb City Mo

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sedan Kans. DATE OF BURIAL Jan. 10 1930

20. UNDERTAKER Steele M. Co. ADDRESS Webb City, 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 Jasper Registration District No. 417 File No. _____
 Township _____ Primary Registration District No. 3081 Registered No. 2
 City Webb City (No. _____) St. _____ Ward _____

2. FULL NAME

(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 F 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) Sept. 4 - 1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
X 34 X 4 3

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 3/31/30 R. M. Stornow
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 1930

17. I HEREBY CERTIFY That I attended deceased from _____ 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:

Laparotomy Peritonitis
Oophorectomy
Chronic appendicitis
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) (duration) 3 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 DISEASES 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 _____

SUPPLEMENTARY

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