

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

Do not use this space.

25242

1. PLACE OF DEATH

County.....

Registration District No. **791**

1003

Township.....

Primary Registration District No.

City.....

(No. of City Hospital)

File No.

Registered No. **7468**

St.

Ward)

2. FULL NAME

(a) Residence. No. **2165 Sulphur St. 3** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **26** 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)

Female

White

married

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

Earl Leonard

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

Jan 9 - 1883

7. AGE

47

6

15

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

Amusement

(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)

Iowa

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Iowa

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Iowa

14.

INFORMANT (Address)

City Hospital

15.

FILED **25** 19**33**

May Stanley

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

July 27 1930

17. I HEREBY CERTIFY, That I attended deceased from *July 17*, 19**30** to *July 27*, 19**30** that I last saw *her* alive on *July 27*, 19**30**, and that death occurred, on the date stated above, at *8:15 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia #103
(not lta or bronch)
109A
84 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Grain depression*
psychia (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Jay D. Mather* M.D.

725 (Address) *City Hospital*

*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

Memorial Park Cem. 7-28 1930

20. UNDERTAKER

ADDRESS

McLaughlin 1631 mo

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.

Leonard .