

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.

Do not use this space.

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

9200

**1. PLACE OF DEATH**

County Greene  
Township  
City Springfield Mo (No. 524 N Lexington)

Registration District No. 318  
Primary Registration District No.

File No.  
Registered No. 251  
St. Ward

**2. FULL NAME**

(a) Residence, No. 524 N Lexington Ward.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 6, 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
68 8 12

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Merchant

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
Indiana

13. NAME John W. Leaderbrand

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
Germany

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
Germany

17. INFORMANT (ADDRESS) Roy E. Leaderbrand  
524 N. Lexington St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Salonway DATE March 19, 1933

19. UNDERTAKER (ADDRESS) R. E. Higgins  
Springfield Mo

20. FILED 3-19-33 Ralph W. Ferguson  
Registrar

**2. MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 18, 1933

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw him live on March 18, 1933. Death is said

to have occurred on the date stated above, at 5:30 p. m.

The principal cause of death and related causes of importance were as follows:

59  
Dilated Myocardium  
59  
No other contributory causes of importance  
Attendant

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
(What test confirmed diagnosis? history. Was there an autopsy? no.)

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_.

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_ (Signed) Oliver George Connor M.D.

(Address) Springfield Mo

APR 2 1933  
1933  
1933

Dr. C. E. Harrison  
1939 N. Grant

