

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 important.

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

Do not use this space.

1. PLACE OF DEATH

County Macon Registration District No. 528 File No. 21100  
Township \_\_\_\_\_ Primary Registration District No. 4314 Registered No. \_\_\_\_\_  
City Callas (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Helie Leffler  
(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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug 11 1896</u>				
7. AGE YEARS <u>37</u>	MONTHS <u>10</u>	DAYS <u>12</u>	If LESS than 1 day, _____ hrs. or _____ min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>			
	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) <u>Callas</u> (STATE OR COUNTRY) <u>mo</u>				
MOTHER FATHER	13. NAME <u>J L Terrell</u>			
	14. BIRTHPLACE (CITY OR TOWN) <u>Macon</u> (STATE OR COUNTRY) <u>mo</u>			
	15. MAIDEN NAME <u>Amel C Morrison</u>			
	16. BIRTHPLACE (CITY OR TOWN) <u>Macon</u> (STATE OR COUNTRY) <u>mo</u>			
17. INFORMANT <u>Mrs. Fanny Mellich</u> (ADDRESS) <u>Callas mo</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Callas mo</u> DATE <u>June 24 1934</u>				
19. UNDERTAKER <u>Robert S. [unclear]</u> (ADDRESS) <u>Macon mo</u>				
20. FILED <u>6/23</u> 19 <u>34</u> <u>NFT Baker</u> Registrar.				

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 23 1934

22. I HEREBY CERTIFY That I attended deceased from June 1 1934 to June 20 1934  
last saw her alive on June 20 1934 Death is said to have occurred on the date stated above, at 12:30 p.m.  
The principal cause of death and related causes of importance were as follows:  
Encephalitis (letargic) Date of onset June 17 1934  
Chronic End Nephritis  
Albumin

Other contributory causes of importance \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ 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) Dr. E. H. Woodhick  
(Address) Bever, mo

