

FEB 25 1937

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

Do not use this space.

1730

1. PLACE OF DEATH
 County Leavenworth Registration District No. 399
 Township 1st Primary Registration District No. 1002
 City Leavenworth (No. 511 E 4th St) (No. 2)
 Registered No. 511 E 4th St St. _____ Ward) _____

2. FULL NAME Lela Winfield
 (a) Residence, No. 511 E 4th St 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 Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 1901

7. AGE YEARS 36 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 999 31

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 21

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

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT None (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge DATE 1-29-1937

19. UNDERTAKER Sawyer Cusack & Spring (ADDRESS) 1119 E 18th St

20. FILED 1/28, 1937 M. in Leavenworth Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-24-1937

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
 I last saw him _____ at _____ on _____ 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Chronic Pulmonary Tuberculosis
 Date of onset _____

Other contributory causes of importance:
None

Name of operation _____ Date of _____
 What test confirmed diagnosis? Impf Was there an autopsy? Yes

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? Yes
 If so, specify Lucian T. Richardson M. D.
 (Signed) _____ (Address) 1832 Bond St

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.

