

REC'D FEB 11 1939

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

1877

Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 125
(b) Township " Primary Registration District No. 3009 Registered No. 38
(c) City Cape Girardeau (d) Street No. 88 James Hospital St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 141 Robert Joseph Leible St. Perryville, Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 14, 1937

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 3 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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) Perry County, Mo.

13. NAME Vincent A. Leible

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Perry County, Mo.

15. MAIDEN NAME Helen Sauer

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Perry County, Mo.

17. INFORMANT (ADDRESS) Vincent A. Leible Perryville, Mo. R.F.D. #2

18. BURIAL, CREMATION, OR REMOVAL PLACE Biehle Catholic Cem DATE Jan 20, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Bey Funeral Home Perryville, Mo. 121

20. FILED 1-20-39 397m Tompson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/20, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1/6, 1939, to 1/20, 1939

I last saw him alive on 1/19, 1939. Death is said to have occurred on the date stated above, at 12:40 A.M.

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

Bronchial pneumonia
right and left lungs
Empyema left chest

Date of onset

12-26-381-6-39

Other contributory causes of importance:

Name of operation Rib resection left chest Date of 1-7-39

What test confirmed diagnosis? X-ray 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? _____

If so, specify _____

(Signed) P. A. Pether, M. D.

(Address) Cape Girardeau, Mo.

1072

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed

Albert H. Bey

Licensed Embalmer No.

3866

P. O. Address

Berryville, Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSISSIPPI DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

1877
Do not use this space.

1. PLACE OF DEATH
 (a) County Cape G. Registration District No. 125.
 (b) Township Cape G. Primary Registration District No. 3009 Registered No. 38
 (c) City Cape G. (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Robert Joseph Heible
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S
 (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 3 5.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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) _____

FATHER 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/20 1937

22. I HEREBY CERTIFY, That I attended deceased from _____ 1937 to _____ 1937
 I last saw h. _____ alive on _____ 1937. 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:
Brochial Pneumonia
spread left lungs.
Empyema of lip & chest
 Other contributory causes of importance:
These were no complications prior to onset of pneumonia. The pneumonia was the primary disease.
 Name of operation _____ Date of _____
 What test confirmed diagnosis _____ Was the test supervised by _____

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? _____
 If so, specify _____
 (Signed) R. A. Ritter, M. D.
 (Address) Cape G.

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Check in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Local Registrar.

S-1877