

AUG 4 1939

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

25225
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104
(b) Township 1 Primary Registration District No. 3008 Registered No. 195
(c) City Fulton (d) Street No. _____
(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

William Leys
(a) Residence, No. Keyville Missouri St.
(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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 ? ?

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farming
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) Warren county Missouri

FATHER 13. NAME Unknown

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Worship Theophil State Hosp #1 Fulton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Indianola Iowa DATE July 18 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jas M Laughlin Marceline Mo

20. FILED July 16 1939 P. N. Crew Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 15 1939

22. I HEREBY CERTIFY, that I attended deceased from April 25 1939, to July 15 1939
I last saw her alive on July 15 1939. Death is said to have occurred on the date stated above, at 10:57 p.m.
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis Date of onset Indefinite
Generalized Arteriosclerosis Indefinite
93C

Other contributory causes of importance:
Name of operation _____ Date of _____
What test confirmed diagnosis clinical/pathology 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? No
If so, specify _____
(Signed) G. P. Wood _____, M. D.
G. P. Wood
106 (Address) State Hosp #1 Fulton 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.

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

Gas McLaughlin

Licensed Embalmer No. *1274*

P. O. Address *Marceline Mo*

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.