

REC'D SEP 7 1939

Registration District No. \_\_\_\_\_

Primary Registration District No. 5446

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Rural Franklm.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Leander Frank Stepp

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 16 1853  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>0</u>	<u>9</u>	_____ hr. _____ min.

9. Birthplace Rome Georgia  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Swamp

12. Name Joseph Stepp

13. Birthplace Franklin  
(City, town, or county) (State or foreign country)

14. Maiden name W. B. Stepp

15. Birthplace Franklin  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James Leelan Stepp

(b) Address 527 E Monroe

17. (a) Bural (b) Date thereof Aug 25 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director W. Kingner & Co

(b) Address Springfield Mo

19. (a) 8-25-39 (b) Allan Barnes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 527 E Monroe  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23  
year 1939 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from 8/10/39  
\_\_\_\_\_ 19 to 8/23/39 19;  
that I last saw him alive on 8/21/39 19;  
and that death occurred on the date and hour stated above.

Immediate cause of death Senility Duration \_\_\_\_\_

Due to 16

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
23. Signature W. M. Stepp (M. D. or other) MD  
Address Springfield Mo Date signed 8/24/39

PHYSICIAN

Underline the cause to which death should be charged statistically

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.....  
*Ogle Lane Jr.*....., Registered Apprentice No. *232*  
working under my personal supervision.

Signed *Roy A. Lawrie*  
Licensed Embalmer No. *1763*  
P. O. Address *Springfield*

**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.**