

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39638
Registrar's No. 861

Registration District No. 315 Primary Registration District No. 2001

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution: 1812 N Boonville
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

8. (a) PRINT FULL NAME MIKE LEITWEIN
8. (b) If veteran, name war World war 8. (c) Social Security No. _____
5. Color or race white
4. Sex male
6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased oct 26 1889
(Month) (Day) (Year)

8. AGE: Years 50 Months 1 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace Missouri
10. Usual occupation Helper at laundry
11. Industry or business _____
12. Name Arnon Leitwein
13. Birthplace Missouri
14. Maiden name Martha Kalso
15. Birthplace Missouri

16. (a) Informant's own signature Arnon Leitwein
(b) Address 2012 N Boonville
17. (a) Burial (b) Date thereof Nov 28 1939
(c) Place: burial or cremation Green Lawn
18. (a) Signature of funeral director J. W. Klingner & Co.
(b) Address Springfield Missouri
19. (a) 11-128-39 (b) Chas. A. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(d) Street No. 1812 N Boonville
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 26
year 1939 hour 6 minute 10 P. M.
21. I hereby certify that I attended the deceased from Oct 27 1939 to Nov 26 1939;
that I last saw him alive on Nov 24 1939
and that death occurred on the date and hour stated above.
Immediate cause of death ruptured aortic aneurism
Due to chronic bulbar disease
Other conditions _____
Major findings: Of operations _____
Of autopsy no

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____
Signature Arthur D. Smith (M. D. or other) _____
Address 402 E. Court St. Date signed 11/27/39

Kriable

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.....

Roy A. Savin

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.

X