

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

44641

State File No. _____
Registrar's No. 2224

Registration District No. 784 Primary Registration District No. 109

1. PLACE OF DEATH: 2
(a) County St. Louis
(b) City or town Maplewood
(c) Name of hospital or institution: 2607 Sutton
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution none (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State Missouri (b) County St. Louis
(c) City or town Maplewood
(If outside city or town limits, write "RURAL")
(d) Street No. 2607 Sutton
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Lloyd D. Leonard 563
3. (b) If veteran, name war _____ 3. (c) Social Security No. 702-14-6958
4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bessie Leonard 6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased Dec. 19, 1887
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 15 year 1939 hour 4 minute P. M.
21. I hereby certify that I attended the deceased from Oct 1, 1939, to Dec 15, 1939; that I last saw him alive on Dec 15, 1939; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
51 11 26 hr. min.

Immediate cause of death Right hemiplegia
Duration 1 yr.
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

9. Birthplace St. Louis, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Signal Foreman
11. Industry or business Mo. Pac. R. R.
12. Name Wallace Leonard
13. Birthplace N. Y. (City, town, or county) (State or foreign country)
14. Maiden name Emma Frank
15. Birthplace Ill. (City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Bessie Leonard
(b) Address 2607 Sutton
17. (a) Burial Burial (b) Date thereof 12-18-1939 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Hill Cem.
18. (a) Signature of funeral director Jay B. Smith
(b) Address 7456 Manchester
19. (a) DEC 18 1939 (Date received local registrar) (b) [Signature] (Registrar's signature)

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) (e) Means of injury _____
23. Signature T. P. Walker (M. D. or other)
Address 2816 Sulta Ave. Date signed 12/15/39

S.A.

SEP 12 1945

EMERALD
BOSTON
MASS.

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..... *H. J. Burgess*

Licensed Embalmer No. *4029*

P. O. Address *Mayfieldwood*

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.

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

Do not use this space.

1. PLACE OF DEATH

County St. Louis Registration District No. 284 File No. 44641
 Township _____ Primary Registration District No. 109- Registered No. 2224
 City Maplewood No. _____ St. _____ Ward _____

2. FULL NAME

Floyd A. Leonard
 (a) Residence, No. _____ 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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE <u>51</u>	YEARS <u>11</u>	MONTHS <u>26</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		DAYS <u>26</u>
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		If LESS than 1 day _____ hrs. or _____ min.
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)		
13. NAME		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
15. MAIDEN NAME		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL		
PLACE _____	DATE _____	19 _____
19. UNDERTAKER (ADDRESS)		
20. FILED _____, 19 _____		

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h..... alive 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:
Rb. hemiplegia
 Date of onset _____

Other contributory causes of importance:
Cerebral Hemorrhage 8.3.39
 + 12.12.39

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 J. R. Waters M. D.
 (Signed) _____
 (Address) 2812 Antenna Ave

Registrar.

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