

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 738 7376

Registration District No. 2029 Primary Registration District No. 277009 Registrar's No. 521

1. PLACE OF DEATH:

(a) County Marion
 (b) City or town Rural, Mason Township
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: R#3 Hannibal
 (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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion
 (c) City or town Hannibal, R#3
 (If outside city or town limits, write "RURAL")
 (d) Street No. R#3 Hannibal
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Issac Leobetter 313

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife Elsie 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 7 1854
 (Month) (Day) (Year)

8. AGE: Years 85 Months 11 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation FARMER

11. Industry or business _____

12. Name Issac Leobetter Sr

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

14. Maiden name Abba Jakes

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

16. (a) Informant's own signature Will Leobetter

(b) Address R#3 Hannibal Mo

17. (a) Burial (b) Date thereof Feb 8 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SALT LICK Cem.

18. (a) Signature of funeral director James Oldham

(b) Address Hannibal Mo

19. (a) 29-10 (b) W. C. G. Fisher
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5 year 1940 hour 10 minute _____ P. M.

21. I hereby certify that I attended the deceased from Jan - 1 - 1938 to Feb 5 1940
 that I last saw him alive on Jan 20 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to Senility

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN
 Underline the cause to which death should be charged statistically

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 W. C. G. Fisher (M. D. or other) _____

Address Hannibal Mo Date signed 2/9/40

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 Michael J. Blouel

Licensed Embalmer No. 3246

P. O. Address Hannibal, 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.