

STANDARD CERTIFICATE OF DEATH

Registration District No. 817

Primary Registration District No. 4

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Commerce, Mo. Rural R. # 1
(c) Name of hospital or institution: 9 mi. south of Commerce, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution seven years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Herman Leible

8. (b) -If veteran, name war

X X X

8. (c) Social Security No.

X X X

4. Sex Male

5. Color or race white

6. (a) Single, widowed, married, divorced child

6. (b) Name of husband or wife X X X

6. (c) Age of husband or wife if alive X X years

7. Birth date of deceased: April 1 1932
(Month) (Day) (Year)

8. AGE:

Years 7

Months 9

Days 29

If less than one day

9. Birthplace

Commerce

Missouri

10. Usual occupation

school boy

11. Industry or business

X X X

MOTHER FATHER

12. Name Auguat Leible

13. Birthplace Perry County

Missouri

14. Maiden name Ernie Leible

15. Birthplace Charleston

Missouri

16. (a) Informant

August Leible

(b) Address

Route 1. Commerce, Mo.

17. (a)

Burial

(b) Date thereof

1-31-40

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

Calvary Cem. Charleston

18. (a) Signature of funeral director

W. P. H. H. H.

(b) Address

Charleston, Mo.

19. (a)

Jan 31 - 40

Wm. A. H. H.

Date received local registrar

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott
(c) City or town Rural- Route 1. Commerce,
(If outside city or town limits, write "RURAL")
(d) Street No. 9 mi. South of Commerce
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 30
year 1940 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan 16
1940 to Jan 29, 1940
that I last saw him alive on Jan 29, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to _____

Due to _____

Other conditions Otitis media
(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. P. H. H. (M. D. or other) _____

Address Charleston Mo Date signed 1-30-40

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

RECEIVED

District Health Officer No. 2,

District File Number 240-654

Date Filed 2/27/60

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.