

Registration District No. 547

Primary Registration District No. 3077

Registrar's No. 99

1. PLACE OF DEATH:

(a) County Marion
 (b) City or town Hannibal
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
605 S. Main
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 years, months or days) 2

3. (a) PRINT FULL NAME Mary Lida Leake 2nd

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

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

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

7. Birth date of deceased Oct. 9 1861
 (Month) (Day) (Year)

8. AGE: Years 78 7/9 Months 4 3/10 Days 7 If less than one day hr. _____ min.

9. Birthplace _____ (City, town, or county) New York (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Theo Dowling

13. Birthplace _____ (City, town, or county) New York (State or foreign country)

14. Maiden name Rose Gibony

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

16. (a) Informant's own signature Virginia Leake

(b) Address 605 S. Main Hannibal Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 18. 40 (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director James Robinson

(b) Address Hannibal Mo

19. (a) 3-18-40 (Date received local registrar) (b) J. C. Fisher (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion
 (c) City or town Hannibal (If outside city or town limits, write "RURAL")
 (d) Street No. 605 S. Main (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15 year 1940 hour eye minute 45 A. M.

21. I hereby certify that I attended the deceased from July, 1937 to March 15, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Chronic myocarditis</u>	
Due to <u>Sensitivity</u>	
Due to <u>Arthritis</u>	
<u>Inflammation</u>	
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? Yes
 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature Edward Meryl (M. D. or other) _____
 Address Hannibal Missouri Date signed 3-18-40

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.

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. Alfonso*

Licensed Embalmer No. *3246*

P. O. Address *Hennipah 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11689

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 347

Primary Registration District No. 3029

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Warren
(b) City or town Hannibal
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Mary Lida Leavelle

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 98 Months 4 Days 7 If less than one day _____ hr _____ min.

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

10. Usual occupation Neurologist

11. Industry or business at home

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 10, 1940 (b) E. M. Lucke
(Date of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH Month 3 day 15
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
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)
(2) Means of injury _____
23. Signature Bernard Stally (M. D. or other) _____
Address Hannibal, Mo Date signed _____

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

SUPPLEMENTAL COPY

11687 (1940)