S. No. 2
-11-10-39
5-17-39
I X21492

8

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

FILED JUN 1 9 1940 FILED JUN 1 9 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

19797

State File No.

Registration District No. 873 Primary Registration District No. 6157 Registrar's No.

1. PLACE OF DEATH:

(a) County Vernon Montana

(b) ~~City or town~~ Sheldon Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None
(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 Mo (b) County Vernon

(c) City or town Sheldon Mo
(If outside city or town limits write "RURAL")

(d) Street No. R.F. 2
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Annie A. Leedy 3AD

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 E. B. Leedy

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

7. Birth date of deceased August 1 1857
(Month) (Day) (Year)

8. AGE: Years 82 Months 9 Days 19 If less than one day hr. min.

9. Birthplace Knox Co Ohio 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business 9

FATHER
12. Name Unknown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant W B Callahan
(b) Address Palo Alto Calif

17. (a) (Burial, cremation, or removal) (b) Date thereof 5-17-1940
(Month) (Day) (Year)
(c) Place: burial or cremation Dunnegan Cem

18. (a) Signature of funeral director G B Bean & Sons
(b) Address Sheldon Mo

19. (a) 5-16-1940 (Date received local registrar) (b) W L Kobendorfer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13
year 1940 hour 9 minute 50 A.M.

21. I hereby certify that I attended the deceased from Nov. 1, 1939, to May 13, 1940;
that I last saw her alive on 11/1/39, 19
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	6 mos
Due to: Arteriosclerosis of entire vascular system.	
Due to	
Other conditions: Coronary sclerosis (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

94B

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?
(Specify type of place)
While at work? (e) Means of injury

7/16

23. Signature J. G. Bennett D.O. (M. D. or other) 3
Address Jerico Springs, Mo. Date signed 5/13/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 6-40-883
Date Filed 6-13-40

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 _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.