

Registration District No. 701

Primary Registration District No. 4422

1. PLACE OF DEATH: Peek
 (a) County Peek
 (b) City or town Bolivar
 (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 _____
 years, months or days

3. (a) PRINT FULL NAME FLORENCE J LEAVITT
 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 Married
 6. (b) Name of husband or wife J. M. Leavitt
 6. (c) Age of husband or wife if alive 40 years
 7. Birth date of deceased Sept 9 - 1857
 (Month) (Day) (Year)

8. AGE: Years 82 Months 10 Days 20
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Music Teacher

11. Industry or business _____
 MOTHER FATHER {
 12. Name Thomas Baldwin
 13. Birthplace Ohio
 (City, town, or county) (State or foreign country)
 14. Maiden name Esther Galtorth
 15. Birthplace Ohio
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. J. Leavitt
 (b) Address Bolivar

17. (a) _____ (b) Date thereof July 31 - 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director W. Hutcherson
 (b) Address Bolivar Mo

19. (a) 7/30 (b) J. J. Roberts
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Peek
 (c) City or town Bolivar
 (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.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 29 1940
 year 1940 hour 6:30 minute _____ A. M.
 21. I hereby certify that I attended the deceased from May 10
 _____, 1935, to July 26, 1940;
 that I last saw her alive on July 26, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Vascular renal Disease
 Due to _____
 Due to _____
 Other conditions Senility
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____
 PHYSICIAN 121
 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?
6:30
 While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature G. D. Smith (M. D. or other) _____
 Address Bolivar Mo Date signed _____

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.

NON-CEMENT

JUL 2 1945

RECEIVED

District Health Officer No. 7,

District File Number 8-40-1205

Date Filed 8-12-40

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.....

Myself

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Bert Legan

Licensed Embalmer No. 3979

P. O. Address Bolton, 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.