

SEP 23 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28864**

Registration District No. **420**

Primary Registration District No. **5574**

Registrar's No. **70**

1. PLACE OF DEATH:
 (a) County Jefferson
 (b) City or town Rural VALLE
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: R.R. No. 2 DeSoto
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Not in Hospital
 In this community 3 Years
years, months or days

8. (a) PRINT FULL NAME SYLVIA FAYE LEAS. *Jm*
8. (b) If veteran, name war No
8. (c) Social Security No. No

4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced infant
6. (b) Name of husband or wife infant
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 1, 1937
(Month) (Day) (Year)

8. AGE: Years 3 Months 6 Days 2
 If less than one day _____ hr. _____ min.

9. Birthplace Jefferson Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

MOTHER { **12. Name** Arthur Leas.
FATHER { **13. Birthplace** Concordia Mo.
(City, town, or county) (State or foreign country)
MOTHER { **14. Maiden name** Marvina Aders.
FATHER { **15. Birthplace** Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur Leas
(b) Address DeSoto Mo. R.F. #2

17. (a) burail (Burial, cremation, or removal) **(b) Date thereof** Aug. 5, 1940
(Month) (Day) (Year)
(c) Place: burial or cremation DeSoto Mo.

18. (a) Signature of funeral director Lee Mothershead
(b) Address DeSoto Mo.

19. (a) _____ **(b)** _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri **(b) County** Jefferson
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. R. Route No. 2, DeSoto
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 3 year 1940 hour _____ minute 30P. M.

21. I hereby certify that I attended the deceased from Sept. 20 1939, to Aug. 3 1940.
 that I last saw her alive on July 30 1940.
 and that death occurred on the date and hour stated above.

Immediate cause of death: Congenital Syphilis
Spastic paralysis
due to birth injury (?)

Duration
3 years
1 day

Due to _____
 Due to _____

Other conditions 34
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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?
381
 While at work? _____ (Specify type of place)
 _____ (e) Means of injury
23. Signature John W. [unclear] (M. D. or other)
Address DeSoto, Mo. **Date signed** 8/3/40

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

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 *J. Lee Mathushead*

Licensed Embalmer No. *3531*

P. O. Address *..... mi*

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 28864
Registrar's No. 70

Registration District No. 420

Primary Registration District No. 5574

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

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Jesse
(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 _____ years, months or days)

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.

3. (a) PRINT FULL NAME Sylira Faye Leach

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month aug day 3
year 1946 hour _____ minute _____ M.

4. Sex 7 5. Color or race w

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

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) _____

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

8. AGE: Years 3 Months 6 Days 2 If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-18-40 (b) Jeneva Donnell
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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) _____ (f) Means of injury _____

23. Signature Paul V. Mc Kinstry

Address Desoto Mo Date signed _____

SUPPLEMENTAL

