DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 23 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31966

Registration District No. 292 Primary Registration District No. 5411 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Franklin
(b) ~~City or town~~ Rural Boles Twp.
(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 — 3 (Specify whether
In this community — years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3614 Morganford Rd
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME George F. Leich
3. (b) If veteran, name war — 3. (c) Social Security No. —
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Minnie B. Leich 6. (c) Age of husband or wife if alive 37 years
7. Birth date of deceased Mar (Month) 6 (Day) 1901 (Year)

8. AGE: Years 39 37 Months 7 Days 0 If less than one day hr. min.
9. Birthplace St Louis (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation Chauffeur 0
11. Industry or business Trucking 0
FATHER
12. Name Friedrich Leich
13. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name Katherine Hagenaecker
15. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
16. (a) Informant Minnie Leich
(b) Address 3614 Morganford St Louis Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/40 (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis Mo
18. (a) Signature of funeral director Biedenweiden
(b) Address 1936 St. Louis, Mo
19. (a) 10-6-40 (Date received local registrar) (b) Mary B. Bross 26 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6
year 1940 hour 1 minute 30 A.M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Conflagration
Auto accident
Due to Head on collision
Due to
Other conditions (Include pregnancy within 3 months of death) 21 22

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) Accident
(b) Date of occurrence 10/6/40
(c) Where did injury occur? Boles Twp. (City or town) Franklin (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place Hy 66 4 mi W. Pacific (Specify type of place)
While at work? Yes (e) Means of injury Auto Accident
23. Signature Chas. P. Shoffer (M.D. or other) Coroner
Address Sullivan, Mo Date signed 10/6/40

(Licensed Embalmer's Statement on Reverse Side)

APR 10 1959

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-2-21-40
I X22659

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STANDARD CERTIFICATE OF DEATH

State File No. 31966

Registration District No. 293 Primary Registration District No. 5411 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Franklin
(b) ~~City or town~~ Boles T. P.
(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 Geo. F Leich
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years.
7. Birth date of deceased Mar 6 1901 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	39	7	0	hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director Buderwieden
(b) Address St Louis Mo
19. (a) Oct 6 1940 (Date received local registrar) (b) Mary B Gross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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? (Specify type of place)
While at work (e) Means of injury
23. Signature Thos P. Shafer (M. D. or other)
Address Sullivan Date signed