

No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42038

State File No. _____

Registration District No. 1111

Primary Registration District No. 5163

Registrar's No. _____

4

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

1. PLACE OF DEATH: Callaway
 (a) County Callaway
 (b) City or town Bellevue Liberty
 (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 _____

3. (a) PRINT FULL NAME EMILY FISK LEACH
 3. (b) If veteran, name war ✓
 3. (c) Social Security No. None

4. Sex F 5. Color or race white 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife Clayton S. Leach 6. (c) Age of husband or wife if alive 6 years
 7. Birth date of deceased Apr 1859
 (Month) (Day) (Year)

8. AGE: Years 81 Months 8 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Jacques Wright

13. Birthplace Boone Co Mo.
 (City, town, or county) (State or foreign country)

14. Maiden name Leason McMurtry

15. Birthplace Shelby Co. Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. B. H. Stephens
 (b) Address Stephens Mo.

17. (a) Buried (b) Date thereof 12-15-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Zion - Boone Co.

18. (a) Signature of funeral director M. J. McDaniel
 (b) Address Bellevue Mo.

19. (a) 12/10-1940 (b) B. H. Stephens
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Callaway
 (c) City or town Hutton Rural
 (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 Dec day 13 year 1940 hour 10 minute 59 M.

21. I hereby certify that I attended the deceased from 12/13/40 to 12/13/40, 19____; that I last saw him alive on 12/13/40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myo condition

Due to _____

Due to ASC

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? NO

While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature M. J. McDaniel (M.D. or other) _____
 Address Centralia Mo. Date signed 12/15/40

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

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 *W. McDonald*.....
Licensed Embalmer No. *2589*
P. O. Address *Quebec, N.S.*

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, fact should be so stated above.