

Registration District No. 365

Primary Registration District No. 5-5-11

Registrar's No.

1. PLACE OF DEATH:

(a) County Shickler  
 (b) City or town Wheatland Mo.  
 (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 Mo. (b) County Hunter  
 (c) City or town Wheatland  
 (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.

8. (a) PRINT FULL NAME Eva Pearl Leist

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex fm 5. Color or race wh 6. (a) Single, widowed, married, divorced married

7. (b) Name of husband or wife Chas A Leist 8. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 1 1879  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	61	4	21	hr. min.

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

10. Usual occupation Wife

11. Industry or business \_\_\_\_\_

12. Name Newton Meador

13. Birthplace Ill  
 (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Stewart

15. Birthplace N. Y.  
 (City, town, or county) (State or foreign country)

16. (a) Informant Arene Todd

(b) Address Wheatland Mo.

17. (a) burial (b) Date thereof 12/23/40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Basque Cem

18. (a) Signature of funeral director JR Fricker

(b) Address Wheatland Mo.

19. (a) Dec 23 1940 (b) Mrs A.S. Johnston  
 (Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month Dec day 22  
 year 1940 hour 1 minute 30 M.

21. I hereby certify that I attended the deceased from April 1938 to Dec-22-1940, that I last saw her alive on Dec-20-1940 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lower jaw & side of neck Duration 2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature A.S. Johnston M.D. (M. D. or other) \_\_\_\_\_

Address Wheatland Mo. Date signed 12-23-40

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

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

2  
1-10-39  
17-39  
X21492

3

123 JAN 25 1941

45

W - 82 - 3221 90  
- 02 - 3221

W - 82 - 3221  
90

RECEIVED

District Health Officer No. 7

District File Number 1-41-77

Date Filed 1-10-41

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. Luckey*

Licensed Embalmer No.

P. O. Address

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. 42661

Registration District No. 365

Primary Registration District No. 5511

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH,

(a) County Victoria  
(b) City or town Wheatland 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)

3. (a) PRINT FULL NAME Eva Pearl Gist

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 60 Months 4 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Dec day 22  
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.

Immediate cause of death carcinoma lower jaw and side of neck

Due to lower lip

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death) 45

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? \_\_\_\_\_

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

23. Signature A. S. Johnston (M. D. or other) M. D.

Address Wheatland Mo Date signed 3-6-41

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

SUPPLEMENTARY

