

No. 2
1-10-39
14539
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42696**

N 25 1041

384

Registration District No. **384**

Primary Registration District No. **4227**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Hawaii**
(b) City or town **West Plains MO**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **11 yrs** _____ (Specify whether)
years, months or days **2**

3. (a) PRINT FULL NAME **Leah Marie**

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

4. Sex **70** 5. Color or race **Blk** 6. (a) Single, widowed, married, divorced **W**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **unknown**
(Month) (Day) (Year)

8. AGE: Years **about 70** Months **4** Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **House work**

11. Industry or business _____

12. Name **unk**

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 **Riley Smith**

(b) Address **West Plains MO**

17. (a) **13** (b) Date thereof **10-24-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hadie Brown**

18. (a) Signature of funeral director **Robert**

(b) Address **West Plains MO**

19. (a) **12-15-40** (b) **Vida W. SIMONS**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Hawaii**
(c) City or town **West Plains MO**
(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 **10** day **23**
year **1940** hour **8:30 P.M.** minute _____ M.

21. I hereby certify that I attended the deceased from **July 13, 1940** to **July 15, 1940**, that I last saw her alive on **July 13, 1940** and that death occurred on the date and hour stated above.

Immediate cause of death: **Myo-carditis, chronic.**

Due to **Obesity.**

Due to _____

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **None made.**

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? **3111**

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

23. Signature **A. Thornburg** (M. D. or other) **M.D.**

Address **West Plains, MO.** Date signed **12/13/40**

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 5,
District File Number 14111
Date Filed _____

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.