

FILED JAN 22 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44190

Registration District No. 893

Primary Registration District No. 6196

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wayne
 (b) City or town Lowndes
 (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 _____
 In this community 5 years _____
 years, months or days _____
 (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wayne
 (c) City or town Lowndes
 (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 Albert Leistner

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 Single

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

7. Birth date of deceased May 14, 1865
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>7</u>	<u>5</u>	hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Edward Paske

(b) Address Lowndes, Missouri

17. (a) Removal (b) Date thereof Dec. 19, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Illinois

18. (a) Signature of funeral director Croy Funeral Service

(b) Address Greenville, Missouri

19. (a) Dec. 24, 1940 (b) J. F. Wagner
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 19
 year 1940 hour 9:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from Dec 18-40
 _____, 19 _____ to Dec 19, 1940;
 that I last saw him alive on Dec 18, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral hemorrhage Duration 12-18-40

Due to Arterio Sclerosis

Due to _____

Other conditions J. F. Wagner
 (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? _____

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

23. Signature J. F. Wagner (M. D. or other M.D.)

Address Greenville, Mo Date signed _____

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

MOTHER FATHER

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~~ XXXXXX
XXXXXX, Registered Apprentice No. XXXX
working under my personal supervision.

Signed.....

Licensed Embalmer No. 3859

P. O. Address Poplar Bluff, Missouri

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.