

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 272

Primary Registration District No. 5518

Registrar's No. 1864

1. PLACE OF DEATH: Holt  
 (a) County Holt  
 (b) City or town Near Hannibal  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 84 years, months or days

3. (a) PRINT FULL NAME Charles Austin Lease  
 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, Widowed  
 6. (b) Name of husband or wife Laura E. Lease 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased July 14th, 1856.  
 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>84</u>	<u>6</u>	<u>12</u>	hr. _____ min. _____

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

10. Usual occupation Farmer.

11. Industry or business \_\_\_\_\_  
 MOTHER FATHER { 12. Name Tobias Lease  
 13. Birthplace Ohio (City, town, or county) (State or foreign country)  
 14. Maiden name Mary Jane Lease  
 15. Birthplace Ky. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature James J. Lease  
 (b) Address Fresh City, Mo.

17. (a) Burial (b) Date thereof Jan. 30/41  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest City, Mo.  
 18. (a) Signature of funeral director H. C. Hoffman  
 (b) Address Mound City, Mo.  
 19. (a) 1-30-41 (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County Holt  
 (c) City or town Rural. (If outside city or town limits, write "RURAL")  
 (d) Street No. Rural. (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month June day 26  
 year 1941 hour 10 minute 0 M.  
 21. I hereby certify that I attended the deceased from Nov 16, 1940, to June 26, 1941  
 and that I last saw him alive on June 22, 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage  
 Duration \_\_\_\_\_

Due to arterio sclerosis  
 Due to \_\_\_\_\_

Other conditions (include pregnancy within 5 months of death) g. 27

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? 333  
 (Specify type of place) While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature H. C. Hoffman (M. D. or other) \_\_\_\_\_  
 Address Mound City Date signed 1-28-41

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**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.**