

FILED FEB 17 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH ✓

State File No. 3383

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 27

## 1. PLACE OF DEATH:

- (a) County Marion  
 (b) City or town Harrison  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
ST. ELIZABETH HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 14 hrs.  
 (Specify whether  
 In this community 0  
 years, months or days)

3. (a) PRINT FULL NAME Arch O. Leonard3. (b) If veteran,  
name war3. (c) Social Security  
No.4. Sex Male 5. Color or race White 6. (a) Single, widowed, married,  
divorced Married6. (b) Name of husband or wife Lettie 6. (c) Age of husband or wife if  
alive 64 years7. Birth date of deceased OCT. 27, 1874  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
67 66 2 8 hr. min.9. Birthplace: Rolls County, Mo  
(City, town, or county) (State or foreign country)10. Usual occupation Police Officer

11. Industry or business

MOTHER { 12. Name Chas. Leonard  
 13. Birthplace MO  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Nancy Jane Wilson  
 15. Birthplace MO  
 (City, town, or county) (State or foreign country)

16. (a) Informant Chas. Leonard(b) Address 1511 Broadway, Harrison, Mo17. (a) Burial (b) Date thereof Jan. 6, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation MT Olivet Cem18. (a) Signature of funeral director James O. Jones  
(b) Address Harrison, Mo  
19. (a) Jan. 17, 1941 (b) W. C. Fisher  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Marion 64  
 (c) City or town Harrison 3  
 (If outside city or town limits, write "RURAL") 4  
 (d) Street No. 1511 Broadway  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 0 years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 4  
year 1941 hour minute 2P M.21. I hereby certify that I attended the deceased from Jan - 3, 40  
1941, to Jan 4, 1941,  
that I last saw him alive on Jan 3, 1941,  
and that death occurred on the date and hour stated above.Immediate cause of death Cardio-vascular - Renal  
Failure Duration 7

Due to

Due to 12/10Other conditions  
(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?  
488 (Specify type of place)  
 While at work? (e) Means of injury

23. Signature W. C. Fisher (M. D. or other) D  
Address Harrison, Mo Date signed Jan 17, 1941

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

**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

*Michael J. D'Annunzio*

Licensed Embalmer No. *3246*

P. O. Address *Hannibal, Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 3383

Registration District No. 547

Primary Registration District No. 3029

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

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Hannibal  
(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 Arch O Leonard

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

4. Sex m 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 \_\_\_\_\_ year

7. Birth date of deceased Oct - 27 - 1874  
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days 27 If less than one day \_\_\_\_\_ 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) 4/4/41 (b) E. M. Lucke  
(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.

19. MEDICAL CERTIFICATION  
20. DATE OF DEATH Month Jan day 4  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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) \_\_\_\_\_  
(c) Means of injury \_\_\_\_\_

23. Signature J. M. Frayless (M. D. or other) \_\_\_\_\_  
Address Hannibal MO Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

