

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
202 Belle Ave. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 28 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Lissouri (b) County Saline
(c) City or town Marshall
(If outside city or town limits, write "RURAL")
(d) Street No. 202 belle AVE.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Cora Lee Leonard

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

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

6. (b) Name of husband or wife James H. Leonard 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased June 16 1866
(Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 28 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

12. Name John B. Lewis

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

14. Maiden name Elizabeth Addis
(City, town, or county) (State or foreign country)

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

16. (a) Informant Lary I. Leonard
(b) Address Marshall, Mo.

17. (a) Burial (b) Date thereof Feb. 16, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Asbury Chapel

18. (a) Signature of funeral director J. Leslie Sumner

(b) Address Marshall Mo.

19. (a) 2-16-43 (b) Miss T. Alkethrook
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14 year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from Feb 13 1943 to Feb 14 1943 that I last saw her alive on Feb 13 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Supposedly pneumonia 2 days

Due to.....

Due to.....

Other conditions Rheumat
(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?

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

23. Signature [Signature] (M. D. or other).....

Address Marshall Date signed.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

No. 5-42
17-39
X32873

FATHER {
MOTHER {

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 3-5-43

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.....

J. Leslie Sussman

Licensed Embalmer No. 32350

P. O. Address W. Ashell, n.c.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7786

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall
(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 years, months or days) 28 yrs

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline

(c) City or town Marshall
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Cora L. Leonard

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 W

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

7. Birth date of deceased June - 16 - 1886
(Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days _____ 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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 14 Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him/her alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death prostatic pneumonia

Due to Bronchitis

Due to diabetes

Other conditions U
(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)

(b) 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 _____ (M. D. or other)
Address Marshall Mo Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

