

FILED JUN 9 1943  
Registration District No. 2052

Primary Registration District No. 2052

1. PLACE OF DEATH: **Pettis**

(a) County: **Pettis**

(b) City or town: **Sedalia**

(c) Name of hospital or institution: **Bothwell Hospital**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: **3 Days**

In this community: **Life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Mo.** (b) County: **Pettis**

(c) City or town: **Sedalia**

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

(d) Street No. **644 E 10th**

(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country: **7 4**

3. (a) PRINT FULL NAME: **Clyde E Leiter**

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: **Mary Leiter**

6. (c) Age of husband or wife if alive: **1876** years

7. Birth date of deceased: **August 19 1876**

(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<b>66</b>		<b>9</b>	<b>15</b>	hr. min.

9. Birthplace: **Sedalia Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation: **Retired**

11. Industry or business: **Groceryman**

12. Name: **Lewis Leiter**

13. Birthplace: **Zanesville Ohio** (City, town, or county) (State or foreign country)

14. Maiden name: **Annie Mathews**

15. Birthplace: **Zanesville Ohio** (City, town, or county) (State or foreign country)

16. (a) Informant: **Mrs John Boston**

(b) Address: **Sedalia Mo.**

17. (a) **burial** (b) Date thereof: **June 5 1943**

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Crown Hill**

18. (a) Signature of funeral director: **McLaughlin Bros**

(b) Address: **Sedalia Mo.**

19. (a) **6-5-43** (b) **Mrs Anna Berger**

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **4th**

year **1943** hour **5:15 AM** minute **..** M.

21. I hereby certify that I attended the deceased from **over 15 years**

that I last saw him alive on **June 2nd** 19**43**

and that death occurred on the date and hour stated above.

Immediate cause of death: **Chc Myocarditis - Decompensated** Duration **4 mos.**

Due to: **Chc Glomerular Nephritis** **5 years**

Due to: **Arterio Sclerosis -** **5 years**

Other conditions: **Diabetes** **15 years**

(Include pregnancy within 3 months of death)

Major findings: **None -**

Of operations: **61**

Of autopsy: **None**

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) **no**

(b) Date of occurrence: **none**

(c) Where did injury occur? **none** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **no**

While at work? **no** (Specify type of place) (e) Means of injury: **0**

23. Signature: **Jno. B. Carlisle M.D.** (M. D. or other)

Address: **Sedalia Mo.** Date signed: **6-5-43**

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

80  
6  
4

RECEIVED

District Health Officer **No. 8**

District File Number \_\_\_\_\_

Date Filed 7-8-43

**JUN 9 1943**

**AUG 25 1947**

**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 Robert H. Reed

Licensed Embalmer No. 3745

P. O. Address Sealonia Mo

**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.