

SEP 9 1943

Registration District No. 378350 Primary Registration District No. 4552 Registrar's No. 37

1. PLACE OF DEATH:
(a) County Texas
(b) City or town Mountain Grove
(c) Name of hospital or institution: Mountain Grove
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 18 yrs. (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Texas 107
(c) City or town MTN. GROVE
(If outside city or town limits, write "RURAL")
(d) Street No. RURAL
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lane Williams Leonard
3. (b) If veteran, name war _____ No. _____
3. (c) Social Security _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 1, 1862
(Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days 4 If less than one day _____ min.

9. Birthplace ALLAN County, Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Calvin Williams
13. Birthplace Warren Co., Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Weaver
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Austin Williams

(b) Address MTN. GROVE, MO

17. (a) BURIAL (b) Date thereof 8-17-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cheto PA, KANSAS

18. (a) Signature of funeral director Russell Baker

(b) Address Intn. Grov. Mo.

19. (a) 8-6-43 (b) H. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5
year 1943 hour 10 minute PM
21. I hereby certify that I attended the deceased from 1/10/43
1943 to 8/3/43 1943
that I last saw her alive on 8/1/43 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Atherosclerosis Duration 2 mo.
Due to chronic myocarditis 3 yrs

Other conditions (Include pregnancy within 3 months of death) 93d

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 W.A. Craig (M. D. or other) D.O.
Address Intn. Grov. Mo. Date signed 8/6/43

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

RECEIVED

District Health Officer No. 5,

District File Number 943523

Date Filed 9-7-52

OCT 10 1952

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 Russell Barber
Licensed Embalmer No. 3848
P. O. Address ret. Home, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 37

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Orange, Clinton Twp.
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Jane Williams 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 Feb 1 1943
(Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days 4 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 19 Year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

Other 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)

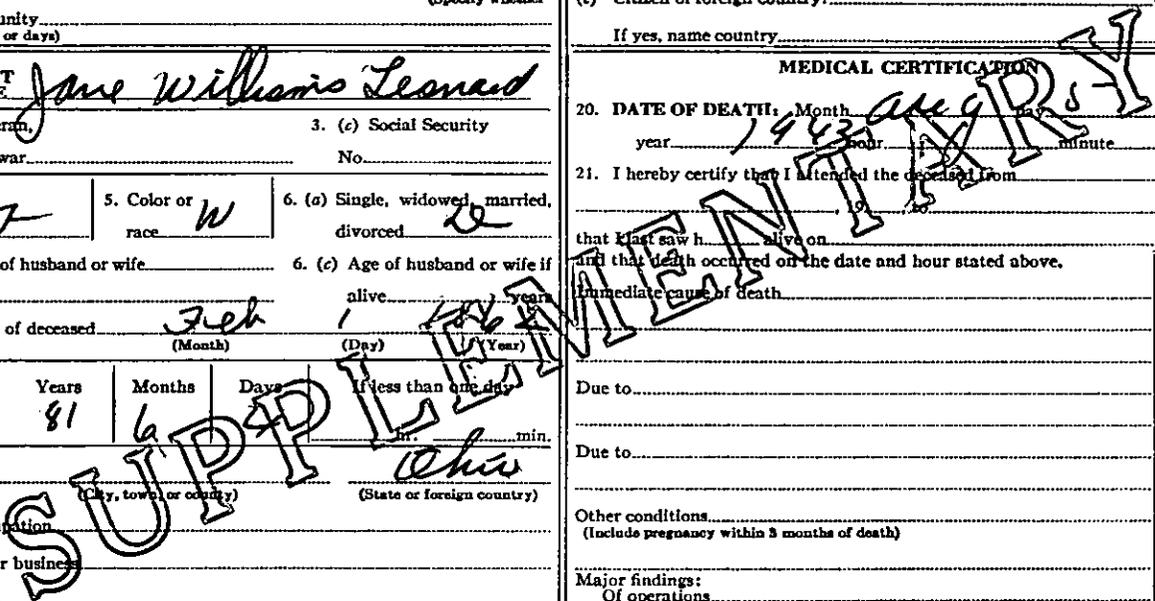
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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



SEP 20 1943

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