

S. No. 2  
OM--5-42  
v. 5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43011  
State File No. \_\_\_\_\_  
Registrar's No. 4

FILED JAN 12 1944  
Registration District No. \_\_\_\_\_

Primary Registration District No. 2043

1. PLACE OF DEATH:  
(a) County Hannibal (Marion Co.) Mo.  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution:  
ST. Elizabeths Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 18 Hours  
(Specify whether \_\_\_\_\_)  
In this community 64 Yrs.  
years, months or days

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

3. (a) PRINT FULL NAME Lillie May Leake

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 2  
6. (b) Name of husband or wife Alonzo Leake (Deceased) 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan 8 1974  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
69 II I5 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Samuel O. Brownfield

13. Birthplace Hannibal Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Carolina Nichols

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

16. (a) Informant Mrs. Bula Bunion

(b) Address Dodge City Kan.

17. (a) Emmerson Cem. Date thereof 12-27-1943  
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Emmerson Mo.

18. (a) Signature of funeral director A. O. Sprague  
(b) Address Palmyra Mo.

19. (a) 1/3/44 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 31 1943  
year \_\_\_\_\_ hour 7 minute 45 A.M.

21. I hereby certify that I attended the deceased from Dec 20 1943 to Dec 27 1943;  
that I last saw her alive on Dec 27 1943;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
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)  
Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Palmyra Mo Date signed 1/3/44

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..... *A. M. Sprague*.....  
Licensed Embalmer No. *999*.....  
P. O. Address..... *Palmyra Pa. P. O. Box*.....

**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. Jan  
Registrar's No. 4

Registration District No. 209

Primary Registration District No. 3043

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 \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Lillie May Leake

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 widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased: Jan 8 (Month) (Day) (Year)

8. AGE: Years 69 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Mo. (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 \_\_\_\_\_ (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 Jan 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 pneumonia Duration \_\_\_\_\_

Due to bronchial pneumonia

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 [Signature] (M. D. or other)

Address [Address] Date signed 1/27/44

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

SUPPLEMENTAL

S-43011