

State File No. _____

Registration District No. 112

Primary Registration District No. 5428

Registrar's No. _____

1. PLACE OF DEATH: FRANKLIN

(a) County FRANKLIN

(b) City or town SULLIVAN, Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 Jump
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 59 Years. (Specify whether years, months or days)

In this community 59 Years.

2. USUAL RESIDENCE OF DECEASED: 36

(a) State Missouri (b) County Franklin

(c) City or town Sullivan, Rural
(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.? 0 years.

8. (a) PRINT FULL NAME: LESETTA KLEAGER

8. (b) If veteran, name war No

8. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____

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

7. Birth date of deceased February 11, 1859
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>10</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER

12. Name John Mincemeyer

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

14. Maiden name Anna Cobley

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

16. (a) Informant Mrs. Anna Underwood

(b) Address Bourbon, Mo. R.

17. (a) Burial (b) Date thereof Dec 27, 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Japan Cemetery

18. (a) Signature of funeral director Wm. P. Shaffer

(b) Address Sullivan, Missouri

19. (a) Jan 17 - 44 (b) Shaffer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 25th
year 1943 hour 3 minute 50 AM.

21. I hereby certify that I attended the deceased from 4/25/43
12-23, 1943 to _____, 19____

that I last saw h. _____ alive on _____, 19____

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

Immediate cause of death arteriosclerosis

arteriosclerosis

Due to _____

Due to _____

Other conditions (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)

(a) Means of injury _____

23. Signature L. H. Garner (M. D. or other) DO.

Address Sullivan, Mo. Date signed 12/28/43

Duration

2

3

7

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Edgar W. Taffson
Licensed Embalmer No. 3394
P. O. Address Sullivan N

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.

FEB 11 1943

Registration District No. 112

Primary Registration District No. 5428

State File No. _____

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Rural - Boone 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 _____ years, months or days 59

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Franklin
(c) City or town Rural - Boone twp.
(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 Lesetta Kleager

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 11 (Month) (Day) (Year)

8. AGE: Years 84 Months 10 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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 Dec day 5 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last 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 _____

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

SUPPLEMENTAL

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

FILED

2754