

No. 2
-2-43
-17-39
X35697

FILED JAN 20 1944

Registration District No. 229

Primary Registration District No. 3013

State File No. _____

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Scott Chaffee

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

(c) Name of hospital or institution: 218 Parker Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no. (Specify whether _____)

In this community 26 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott 190

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

(d) Street No. 218 Parker Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME SARAH ELIZABETH LEACH

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13
year 1944 hour 6 minute 33.4 M.

21. I hereby certify that I attended the deceased from Dec. 28 - 1943 to Jan. 13 1944
that I last saw her alive on Jan. 13 1944
and that death occurred on the date and hour stated above.

4. female 5. Color or race white 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Joseph Eli Marcus Leach 6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased March 16 1861
(Month) (Day) (Year)

Immediate cause of death: Influenza with bronchial symptoms

Due to _____

Due to _____

8. AGE: Years 82 Months 9 Days 28
If less than one day _____ hr. _____ min.

Other conditions: Senility
(Includes pregnancy within 3 months of death)

Major findings: 120
Of operations: 20

Of autopsy _____

9. Birthplace: Cape Girardeau Co Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business _____

12. Name: Hope (air name)

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

14. Maiden name: Do not know

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant: J. L. Leach
(b) Address: St. Louis

17. (a) BURIAL (b) Date thereof 1-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Union Park Chaffee

18. (a) Signature of funeral director: B. S. Loughoff Rd. 666
(b) Address: Chaffee, Mo.

19. (a) Jan 14-44 (b) Christine Grace
(Date received local registrar) (Registrar's signature)

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: Mabel M. Delaney (M. D. or other) D.O.
Address: Chaffee - Mo. Date signed 1/13/44

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

RECEIVED

District Health Office No. 2,

District File Number 14-154

Date Filed 1-17-44

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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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.