S. No. 2
I—9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 26 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35288

Registration District No. 317 Primary Registration District No. 3069 Registrar's No.

1. PLACE OF DEATH:
(a) County Clayton
(b) City or town ST LOUIS MO CO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St MARY
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 MONTHS (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County NEW MADRID
(c) City or town NEW MADRID
(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 JERRY LEE LEONBERGER
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
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased FEB (Month) 3 (Day) 1944 (Year)

8. AGE: Years	Months	Days	If less than one day
	6	6	hr. min.

9. Birthplace NEW MADRID (City, town, or county) MO (State or foreign country)
10. Usual occupation NONE
11. Industry or business NON
FATHER
12. Name HARRY LEONBERGER
13. Birthplace Ky. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name RUBY LINDSEY
15. Birthplace NEW MADRID (City, town, or county) MO (State or foreign country)
16. (a) Informant James O Lindsey
(b) Address New Madrid MO
17. (a) BURIED (Burial, cremation, or removal) (b) Date thereof 2-13-44 (Month) (Day) (Year)
(c) Place: burial or cremation MOUND CEMETERY
18. (a) Signature of funeral director L M Hall
(b) Address Lilbourn MO
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9 year 1944 hour 3 minute 25 A.M.
21. I hereby certify that I attended the deceased from MAY 19 1944, to Aug 9 1944; that I last saw him alive on August 9 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hydrocephalus	6mo
Due to	
Due to	
Other conditions Meningocoele (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

15 na

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? (Specify type of place)
While at work (e) Means of injury
23. Signature Jackson Gto (M. D. or other)
Address 6420 Clayton Road Date signed 8/10/44

844

(Licensed Embalmer's Statement on Reverse Side)

SEP 27 1940

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 L H Hill

Licensed Embalmer No. 2627

P. O. Address Lilbourn Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
—5-43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29554

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 1696

1. PLACE OF DEATH:

(a) County

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

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

(d) Length of stay: In hospital or institution (Specify whether
In this community 4 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town New Madrid
(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 Jerry L. Leonberger

3. (b) If veteran name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb - 3 (Month) 1944 (Day) (Year)

8. AGE: Years | Months 6 | Days 6 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Harry Leonberger
13. Birthplace (City, town, or county) Ky (State or foreign country)

MOTHER
14. Maiden name Ruby Lindsey
15. Birthplace New Madrid Mo. (City, town, or county) (State or foreign country)

16. (a) Informant J. O. Lindsey
(b) Address New Madrid Mo.

17. (a) (Burial, ~~cremation, or removal~~) (b) Date thereof 2-13-44 (Month) (Day) (Year)

(c) Place: burial or cremation Mound Cemetery

18. (a) Signature of funeral director L. H. Hall
(b) Address Lilbourn Mo.

19. (a) 8/15/44 (Date received local registrar) (b) E. G. McGowan M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 9 1944
year hour minute M.

21. I hereby certify that I attended the deceased from
, 19 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 Hydrocephalus — Duration 6 mo

Due to

Due to

Other conditions Meningocele
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

35288