

S. No. 2  
4-8-43  
5-17-39  
P 1 X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 9 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **87698**  
Registrar's No. **45**

Registration District No. **114** Primary Registration District No. **5432**

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

1. PLACE OF DEATH:  
(a) County **Franklin**  
(b) City or town **Stanton - rural Meramec**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) **1**  
(d) Length of stay: In hospital or institution. **1**  
In this community **life**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Franklin**  
(c) City or town **Stanton - rural Meramec**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **36**  
(If rural, give location) **6**  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **?**

3. (a) PRINT FULL NAME **Carolyn Mae Leath**  
3. (b) If veteran, name war  
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **11** day **18**  
year **1944** hour **6** minute **20** M.  
21. I hereby certify that I attended the deceased from **12:20 a.m.**  
**11-18** **44** to **11-18** **44**  
that I last saw her alive on **11-18** **44**  
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color of hair **White** 6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive **1944** years  
7. Birth date of deceased **Nov. 18 1944**  
(Month) (Day) (Year)

Immediate cause of death **atelectasis**  
Duration **10 hours**  
Due to **159**

8. AGE: Years Months Days If less than one day  
**17 hr. 40 min.**  
9. Birthplace **Stanton - rural Meramec Mo**  
(City, town, or county) (State or foreign country)

Other conditions **Prematurity (8 mos) and poor nutrition & mother**  
Major findings: **None**  
Of operations **None**  
Of autopsy **None**  
PHYSICIAN **None**  
Underline the cause to which death should be charged statistically.

10. Usual occupation **None**  
11. Industry or business **None**  
MOTHER, FATHER { 12. Name **Myles Leath**  
13. Birthplace **Kell - Mo**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Anna Pearl Adams**  
15. Birthplace **Leasburg - Mo**  
(City, town, or county) (State or foreign country)  
16. (a) Informant **C. A. Prater - M.D.**  
(b) Address **Sullivan - Mo**  
17. (a) **Burial** (b) Date thereof **11-20-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Stanton - Mo**  
18. (a) Signature of funeral director **None**  
(b) Address  
19. (a) **11-18-44** (b) **Gilbert Gillogay**  
(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)  
(e) Means of injury **?**  
23. Signature **C. A. Prater** (M. D. or other)  
Address **Sullivan Mo** Date signed **11-20-44**

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed 12-8-44

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.