

FILED JAN 11 1945
 Registration District No. **200**

Primary Registration District No. **3041**

Registrar's No. **122**

1. PLACE OF DEATH

(a) County **Macon**
 (b) City or town **Macon**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Stamant Hospital**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **13 days**
(Specify whether)
 In this community
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Macon**
 (c) City or town **Callao**
(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 **Lera Leffler**

3. (b) If veteran, name war
 3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **29**
 year **1944** hour **11** minute **15 P** M.

21. I hereby certify that I attended the deceased from **9-16** 19**44** to **11-29** 19**44**
 that I last saw **h. ER** alive on **11-29** 19**44**
 and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **Wh**
 6. (a) Single, widowed, married, divorced **MARRIED**
 6. (b) Name of husband or wife **John Leffler** 6. (c) Age of husband or wife if alive **85** years
 7. Birth date of deceased **3-22-1866**
(Month) (Day) (Year)

Immediate cause of death: **Carcinoma of the liver metastatic**
 Duration

8. AGE: Years **78** Months **8** Days **7**
 If less than one day hr. min.

9. Birthplace **East Troy Wis**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

Due to **-**
 Due to **468**
 Other conditions (Include pregnancy within 3 months of death) **-**
 Major findings:
 Of operations **-**
 Of autopsy **-**

MOTHER FATHER

12. Name **Gamer W. Randall**
 13. Birthplace **Vermont**
(City, town, or county) (State or foreign country)
 14. Maiden name **Martha Randall**
 15. Birthplace **V. H.**
(City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **John Leffler**
 (b) Address **Callao**
 17. (a) **Burial** (b) Date thereof **12-1-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Callao**

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? **-**

18. (a) Signature of funeral director **W. J. Edwards**
 (b) Address **37 E. 1st**
 19. (a) **12/10/44** (b) **Lera B. Hinkle**
(Date received local registrar) (Registrar's signature)

While at work? **-** (Specify type of place) (c) Means of injury **-**
 23. Signature **L. L. Dunsen**
 Address **Callao, Mo** Date signed **12-9-44**

1037

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

RECEIVED

District Health Officer No. 10

District File Number 1-45-97

Date Filed JAN 9 1945

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: H. G. Edwards

Licensed Embalmer No. 1967

P. O. Address Brewer, 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.