

U. S. No. 2
FORM-8-43
Rev. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5811

State File No.

FILED FEB 19 1945

Registration District No. 59

Primary Registration District No. 5217

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Rural Austin, Mo
(c) Name of hospital or institution 7 Miles S.E. of Harrisonville
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Life in Cass Bates Co.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bates
(c) City or town Rich Hill
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Leroy Meade
3. (c) Social Security name war _____ No _____

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife MINNIE PIERSON MEAD 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased 6-7-1887
(Month) (Day) (Year)

8. AGE: Years 57 Months 7 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation Common laborer

11. Industry or business _____
12. Name Thomas Mead
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Francis Bazzie
15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Ars. Minnie Mead
(b) Address Rich Hill Mo.

17. (a) Burial (b) Date thereof 2/4/45
(Burial, cremation, or other) (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Atkynson Bros.
(b) Address Harrisonville Mo.

19. (a) Feb 7, 1945 (b) Margaret Tolle
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 6
year 1945 hour 4 minute 30 P.M.
21. I hereby certify that I attended the deceased from Jan 30, 1945, to Feb 6, 1945;
that I last saw him alive on Jan 30, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchietasis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 106 hr

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 J. S. Triplett M.D. (M. D. or other)
Address Harrisonville Mo. Date signed 2-7-45

(Licensed Embalmer's Statement on Reverse Side)

1047

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

900

MOTHER, FATHER

5 1945

APR

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 Personally

....., Registered Apprentice No.

working under my personal supervision.

Signed

Floyd Atkinson

Licensed Embalmer No. 3920

P. O. Address Harrisonville

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.