

FILED MAR 3 1945

Registration District No. **317**

Primary Registration District No. **6064**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Clair - "Rural"

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

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

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 46 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Martha V. Leasure

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 19
year 1945 hour 10 minute 30 A. M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, divorced, widowed

6. (b) Name of husband or wife William (c) Age of husband or wife if 9
Henry Leasure alive _____ years

7. Birth date of deceased: JAN 16 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from January 28, 1944, to February 17, 1945,
that I last saw h. & r. alive on February 17, 1945,
and that death occurred on the date and hour stated above.

8. AGE: Years 80 Months 1 Days 3 If less than one day _____
hr. _____ min. _____

Immediate cause of death Apoplexy

Due to Chronic age

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

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings:
Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name John F. Van Dyke

13. Birthplace Dover Delaware
(City, town, or county) (State or foreign country)

14. Maiden name Mary Wilson

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

16. (a) Informant Joe Van Dyke

(b) Address Osceola, Mo.

17. (a) Burial (b) Date thereof 2-21-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osceola Cemetery

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury 2

23. Signature R. M. ... (M. D. or other) _____

Address Osceola, Missouri Date signed 2/20/45

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

RECEIVED - DISTRICT HEALTH OFFICER NO. 7
DISTRICT FILE NO. LABOR 2-4-5-138
DATE FILED 2-5-45

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 *Paul J. Fontana*

Licensed Embalmer No. 3990

P. O. Address. *Oscarino*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. _____

Registration District No. 314

Primary Registration District No. 6064

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Rural Osceola Jwp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Martha V. Leasure
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 16 1880
(Month) (Day) (Year)

8. AGE: Years 80 Months _____ Day _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof _____
(Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) W. B. Headrick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Clair
(c) City or town Osceola
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

Duration _____
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

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

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

SUPPLEMENTARY

MOTHER FATHER

6997