

S. No. 2
M-2-43
5-17-39
PI X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9401

State File No.

FILED APR 10 1945
65

Registration District No.

Primary Registration District No. 4114

Registrar's No.

1. PLACE OF DEATH:

(a) County CHARITON

(b) City or town Mendon
(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 50 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton

(c) City or town Mendon
(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 ROSA ELLEN LEAKE

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR. day 16
year 1945 hour 12.10 minute A. M.

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased Sept 26 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 8, 1945, to March 16, 1945?
that I last saw her alive on March 15, 1945?
and that death occurred on the date and hour stated above.

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

83 5 18 hr. min.

Immediate cause of death Respiratory Failure (Examine)

Due to Chronic Nephritis 10 yrs.

9. Birthplace Des Moines Co Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation H. Wife

Due to _____

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

11. Industry or business Columbus Kelley

12. Name Columbus Kelley

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

14. Maiden name SABELE TIGHE

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

Major findings: Of operations _____

Of autopsy 4/3/45

16. (a) Informant Mrs Crystal Smith

(b) Address Mendon

17. (a) Burial (b) Date thereof 3/18/45
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Living

18. (a) Signature of funeral director Walter Lipson

(b) Address Mendon Mo

19. (a) 3-18-1945 (b) W. Lipson
(Date received local registrar) (Registrar's signature)

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

23. Signature W. Lipson (M. D. or other) MD

Address Mendon Mo Date signed 3/18/45

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

MOTHER FATHER

102

RECEIVED

District Health Officer No. 5.

District Number

Date / Recd

4/9/45

APR 17 1945

APR 17 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 *J. L. Lipard*

Licensed Embalmer No. *3970*

P. O. Address *Menden 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.