S. No. 2
M—8-43
. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 21 1945

Registration District No. 170

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3033

State File No. 20695

Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede
(c) City or town Lebanon Mo. 53
(If outside city or town limits, write "RURAL")
(d) Street No. 116 Mc Phail
(If rural, give location)
(e) Citizen of foreign country? no 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Leta Haley
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex F ?
5. Color or race Colored
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 4 (Day) 1906 (Year)
8. AGE: Years 48 Months 2 Days 29 If less than one day hr. min.
9. Birthplace Laclede Co. (City, town, or county) Mo. (State or foreign country) 1
10. Usual occupation Public House Keeper
11. Industry or business
MOTHER FATHER
12. Name Arthur Haley
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9
14. Maiden name Anna Givens
15. Birthplace Laclede Co (City, town, or county) Mo. (State or foreign country) 1
16. (a) Informant Mrs Anna Givens
(b) Address 116 Mc Phail Lebanon Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-45 (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery
18. (a) Signature of funeral director W E Holman
(b) Address Lebanon Mo.
19. (a) June-1-45 (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3 year 1945 hour 11 minute 30 P.M.
21. I hereby certify that I attended the deceased from 5-3, 1945 to 5-3, 1945 that I last saw her alive on 5-3, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Apoplexy	
Due to Hypertensive heart disease	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Austin R. Knowles (M. D. or other) D.O.
Address Lebanon, Mo. Date signed 5/4/45

10 90 (Licensed Embalmer's Statement on Reverse Side)

Received .....

Laclede County Health Unit

File No. 5-45-59

Date Filed 6/19/40

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon 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.