S. No. 2
M—2-43

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25883 / 7488

FILED SEP 1 1945

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No.

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

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Frisco Employees Hospital (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 Oklahoma (b) County Oklahoma 971

(c) City or town Oklahoma City (If outside city or town limits, write "RURAL") NR

(d) Street No. 1535 N.W. 32nd St. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Garland J. Leak

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Cora Leak

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased February (Month) 1 (Day) 1887 (Year)

8. AGE: Years 58 | Months 6 | Days 27 | If less than one day hr. min.

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

10. Usual occupation Railroad Inspector

11. Industry or business Frisco R.R.

FATHER

12. Name John Leak

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

MOTHER

14. Maiden name Mary Sigman

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

16. (a) Informant Cora Leak

(b) Address Oklahoma City, Okla.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-28-45 (Month) (Day) (Year)

(c) Place: burial or cremation Oklahoma City, Okla.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) AUG 28 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 28 year 1945 hour 7:00 minute A. M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial Failure	
Due to: Carcinomatosis of abdomen	
Due to: —	
Other conditions: — (Include pregnancy within 3 months of death)	
Major findings: Of operation: Extensive Carcinoma of Abdomen	
Of autopsy	

55 a

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? (c) Means of injury

23. Signature Geo. Hoppe (M. D. or other)

Address 3 W Washington Ave Date signed 8-30-45

(Licensed Embalmer's Statement on Reverse Side)

7488

7488

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 John Ogonoski

Licensed Embalmer No. 3398

P. O. Address.....

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.