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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED AUG 21 1945

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 227

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

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1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: St. Elizabeth Hospital  
(If not in hospital or institution, write street number or location)

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

In this community 20 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 64

(c) City or town Hannibal 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 405 Olive St. 4  
(If rural, give location) 0

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Samuel Lewis Leever

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Mary D. Leever 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased November 20 1868  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25 year 1945 hour 4:45 P.M. minute \_\_\_\_\_

21. I hereby certify that I attended the deceased from July 17 1945 to July 25 1945 that I last saw him alive on July 25 1945 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>8</u>	<u>5</u>	— hr. — min.

Immediate cause of death Brain Cancer Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to Chronic Myeloid Leukemia

Other conditions (include pregnancy within 3 months of death) Enlarged Prostate

9. Birthplace Lewis County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation retired

11. Industry or business Carpenter

MOTHER FATHER { 12. Name Lewis Leever

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

14. Maiden name Marjorie Jane Knight

15. Birthplace unknown 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Norma Ledford

(b) Address 405 Olive Hannibal Mo.

17. (a) Burial (b) Date thereof July 28, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grand View Burial Park

18. (a) Signature of funeral director Ray P. Schwartz

(b) Address 1000 Edwy. Hannibal Mo.

19. (a) 8/9/45 (b) W. E. M. Fuchs  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_

Of autopsy 1312

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 H. M. Guehne (M. D. or other) MD

Address Hannibal Mo. Date signed 8/24/45

159X

**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 \_\_\_\_\_

Licensed Embalmer No. 4110

P. O. Address Anniston, Ala.

**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.**