

**FILED OCT 4 1945** MISSOURI STATE BOARD OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

**31615**  
 Do not use this space.

1. PLACE OF DEATH  
 (a) County Wayne Registration District No. 370  
 (b) Township St. Francis Primary Registration District No. 6258  
 (c) City Silver (d) Street No. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 2. PRINT FULL NAME Mary Ellen Leach  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Calvin M. Leach

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 3 - 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
63      2      18

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co Mo

13. NAME Levi Beasley

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Nancy Johnson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas County Mo

17. INFORMANT Calvin M. Leach (ADDRESS) Silver, Mo

18. BURIAL, CREMATION, OR REMOVAL PLAC Graves Creek Co DATE Aug 22 - 45

19. FUNERAL DIRECTOR Marrhallis (ADDRESS) Greenville, Mo

20. FILED Sept 1st 1945 Mabel Beasley Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 21 - 45

22. I HEREBY CERTIFY, That I attended deceased from July 1945, to Aug 21 - 45, 1945.  
 I first saw her alive on Aug 19 - 45, 1945. Death is said to have occurred on the date stated above, at 6:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Exophthalmic Goiter  
Heart - Arteriosclerosis  
 Date of onset 2 yr

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_ (Signed) John F. Wagner, M. D.  
 (Address) Greenville, Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD  
 MARGIN RESERVED FOR BINDING  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.  
 50M-7-20-37 I X12004

**STATEMENT BY LICENSED EMBALMER**

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
\_\_\_\_\_ L. E. \_\_\_\_\_  
No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 3587

**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.)**