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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12262**

FILED MAY 28 1946

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 387

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: MO. ME. Hospital 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 weeks
(Specify whether)
 In this community 72 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
 (c) City or town Rea mo
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Dollie Gertrude Leese

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife James Leese 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 19 1873
(Month) (Day) (Year)

8. AGE: Years 72 Months 8 Days 12 If less than one day hr. _____ min. _____

9. Birthplace Andrew Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name James B. Baker

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

14. Maiden name MICHAEL PRATTIE

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

16. (a) Informant Baker Leese
 (b) Address Barnard mo

17. (a) B (b) Date thereof 4-4-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SAVANNAH

18. (a) Signature of funeral director E. C. Greif

(b) Address Savannah mo

19. (a) April 3, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 1
 year 1946 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb 7, 1946, to Apr 1, 1946
 that I last saw her alive on Apr 1, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis. Following Extensive burn (3rd degree) Due to both arms & rt side of neck chest, abd. & upper Due to thigh

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

Major findings: General
 Of operations none
 Of autopsy none

PHYSICIAN
 Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? 1
(Specify type of place) (e) Means of injury _____

23. Signature E. M. Dross (M. D. or other) M.D.
 Address 317 1/2 N. Patrick Bldg Date signed 4-2-46

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

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah

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.

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(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 _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 Dollie L. Teese
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH Month _____ Year 1946 hour _____ minute _____ M. _____
21. I hereby certify that I attended the deceased from _____ to _____ 19____; that I last saw him alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased July 19 (Month) (Day) (Year)
8. AGE: Years 72 Months _____ Days _____ If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) 18/15

9. Birthplace Mo (City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 2-6-46
(c) Where did injury occur? at Home Res. Mo. Andrew (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home in a small town
While at work? _____ (Specify type of place)
(c) Means of injury about an open fire
23. Signature S. M. Brown (M. D. or other) MD
Address St. Joseph Mo Date signed 5-10-46

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

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