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7-5-17-39  
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DEPARTMENT OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS  
STANDARD CERTIFICATE OF DEATH

State File No. 22254  
Registrar's No. 283

Registration District No. 209 Primary Registration District No. 3043

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

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution:  
106 South Fourth Street 1  
(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion <sup>67</sup>

(c) City or town Jannibal <sup>3</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. 106 South Fourth St <sup>4</sup>  
(If rural, give location) <sup>10</sup>

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

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

3. (a) PRINT FULL NAME Robert Boyd Leamon

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1  
year 1946 hour \_\_\_\_\_ minute 4<sup>20</sup> A.M.

21. I hereby certify that I attended the deceased from 6/17 1946 to 8/1 1946.  
that I last saw him alive on 6/17 1946  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased October 23 1880  
(Month) (Day) (Year)

Immediate cause of death Unknown Duration \_\_\_\_\_

Due to Cancer of the bowel ?

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

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

8. AGE: Years Months Days If less than one day

<u>65</u>	<u>9</u>	<u>9</u>	_____ hr. _____ min.
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PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_  
Of operations 4/6

Of autopsy \_\_\_\_\_

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

10. Usual occupation Printer

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name John Leamon )

FATHER { 13. Birthplace Missouri )  
(City, town, or county) (State or foreign country)

14. Maiden name Ella Serquoran

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

16. (a) Informant Agnes Proppman

(b) Address Jannibal, Mo.

17. (a) Burial (b) Date thereof 8-3-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prosside's Cemetery

18. (a) Signature of funeral director Jack D. [unclear]

(b) Address Jannibal, Mo.

19. (a) 8-20-46 (b) R. E. M. Lucke  
(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) No

(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)

Means of injury \_\_\_\_\_

23. Signature Shirley L. [unclear] (M. D. or other) <sup>0</sup>

Address 100 [unclear] Date signed 8/20/46

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..... *L.M. O'Connell* .....

Licensed Embalmer No. *3889* .....

P. O. Address..... *Summit, Missouri* .....

**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.