

S. No. 2
-12-45
5-17-39
P I X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29429**
Registrar's No. **252**

FILED SEP 16 1946
Registration District No. _____

Primary Registration District No. **3000**

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

1. PLACE OF DEATH:

(a) County **Adair**

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

(c) Name of hospital or institution:
Grim-Smith Hospital & Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **20 Hours**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Leonard, Della Deady Mrs.**

3. (b) If veteran, name war **✓**

3. (c) Social Security No. **✓**

4. Sex **female**

5. Color or race **White**

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

6. (b) Name of husband or wife **James Harvey**

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

7. Birth date of deceased **John 6 1865**
(Month) (Day) (Year)

8. AGE: **81** Years **7** Months **29** Days If less than one day hr min.

9. Birthplace **Davis County Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **David Lawson**

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

14. Maiden name **Lucinda Hill**

15. Birthplace **S. Carolina**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. E. J. Robb**

(b) Address **Kirkaville, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9-7-46**
(Month) (Day) (Year)

(c) Place: burial or cremation **Green Grove Cemetery**

18. (a) Signature of funeral director **Summers & Powell**

(b) Address **Kirkaville, Mo.**

19. (a) **9-6-46** (Date received local registrar) (b) **Nate Lambert** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Adair**

(c) City or town **Stahl,**
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **2**
year **1946** hour **5** minute **45 A** M.

21. I hereby certify that I attended the deceased from **Sept. 4**
1946, to **Sept 5, 1946**
that I last saw ~~or~~ alive on **Sept 5, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiovascular renal disease**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **131A**

Of autopsy _____

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) (c) Means of injury _____

23. Signature **J. P. King** (M. D. or other) **MD**

Address **Kirkaville, Mo.** Date signed **9/5/46**

Duration

2 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 10
District File Number 9-46-179
Date Filed SEP 1 1946

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 W. C. Summers

Licensed Embalmer No. 2159

P. O. Address Tiskerville, N.C.

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.