

S. No. 2
M-8-43
S-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1955

FILED JAN 20 1947
Registration District No. 251

Primary Registration District No. 3048

State File No. _____
Registrar's No. J

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

1. PLACE OF DEATH:
 (a) County Nodaway
 (b) City or town Maryville, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Francis Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 weeks.
(Specify whether
 In this community 78 Years
years, months or days)

3. (a) PRINT FULL NAME John Clarence Lekey
 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 Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Nov. 26, 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	78	1	14	hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business None

MOTHER FATHER
 12. Name Valentine Lekey
 13. Birthplace Indiana
(City, town, or county) (State or foreign country)
 14. Maiden name Mary McNutt
 15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Lekey
 (b) Address Maryville, Missouri

17. (a) Burial (b) Date thereof 1-13-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wilcox Cemetery
Price Funeral home
 18. (a) Signature of funeral director
 (b) Address 120 E. 1st, Maryville, Mo.

19. (a) 1-11-47 (b) Bess Holt
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Nodaway 74
 (c) City or town Quitman (Rural) 2
(If outside city or town limits, write "RURAL")
 (d) Street No. 6 Mile Northeast 0
(If rural, give location)
 (e) Citizen of foreign country? No 0
(Yes or No)
 If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 10th
 year 1947 hour 9 minute 00 A.M.

21. I hereby certify that I attended the deceased from Dec 13, 1946 to Jan 10, 1947
 that I last saw him alive on Jan 10, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Myocarditis
General arteriosclerosis
 Due to: Cerebral hemorrhage
 Duration 3

Other conditions (Include pregnancy within 3 months of death)
 Major findings: 930
 Of operations _____
 Of autopsy _____

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

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? _____

(Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature B. B. Byrnes (M: D. or other) MD
 Address Maryville Date signed 1/11/47

FEB 3 - 1948

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *J. W. L. G. G.*

Licensed Embalmer No. *2539*

P. O. Address..... *Manlyville Mo*

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.