

FILED MAR 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 9304

BIRTH NO. _____		REG. DIST. NO. <u>228</u>		PRIMARY REG. DIST. NO. <u>5808</u>		Registrar's No. <u>5</u>	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Montgomery City Rural</u>		c. LENGTH OF STAY (In this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>		0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>				d. STREET ADDRESS (If rural, give location) <u>Home</u>			
3. NAME OF DECEASED (Type or Print) <u>Anna Lee Leonard</u>		a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) <u>2 25 1949</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	
8. DATE OF BIRTH <u>4 6 1869</u>		9. AGE (In years) last birthday <u>79</u>		IF UNDER 1 YEAR Month <u>10</u> Days <u>19</u>		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General duties</u>		11. BIRTHPLACE (State or foreign country) <u>Lincoln Co Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Henry Henson</u>		13b. MOTHER'S MAIDEN NAME <u>Thorgie Hulcom</u>		14. NAME OF HUSBAND OR WIFE <u>Mikel Lee Leonard (Dec)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Lorene Leonard</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Haemorrhage</u> DUE TO (c) <u>Artero-Sclerotic Nephritis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 months</u> <u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No.</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Montgomery City Montgomery MO.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>Feb-1</u> , 19 <u>46</u> , to <u>Feb-26</u> , 19 <u>49</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>James O. Helm M.D.</u>				23b. ADDRESS <u>Montgomery City Mo</u>		23c. DATE SIGNED <u>2-26-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-27-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bellflower cem</u>		24d. LOCATION (City, town, or county) (State) <u>Bellflower Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2-28-49</u>		REGISTRAR'S SIGNATURE <u>Mrs May Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Clara A Jones Bellflower</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 3/15/49

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 _____

_____ Me _____ Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed Clara A. Jones _____
Licensed Embalmer No. 2978 _____

P. O. Address Bellflower 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.