

FEB 24 1939  
Dr. Cantrill

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

2996  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Macon Registration District No. 533  
 (b) Township Liberty Primary Registration District No. 5715  
 (c) City 1 (d) Street No. 9  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth, yrs. mos. ds.  
 300  
 2. PRINT FULL NAME Leslie Clark Todd  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF   
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 19 - 1939  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.  
0 0 0 6

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. Infant  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Co., Mo.

FATHER 13. NAME Webster Todd 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Co., Mo.

MOTHER 15. MAIDEN NAME Alta Haught 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Co., Mo.

17. INFORMANT (ADDRESS) Webster Todd, Bevier Mo. R. 1.

18. BURIAL CREMATION, OR REMOVAL PLACE Milam Chapel DATE 1 - 30 - 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stephens & Gooding, Macon, Mo.

20. FILED 276 1939 Bevier Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 19 1939  
 22. I HEREBY CERTIFY That I attended deceased from Jan - 18 1939 to Jan - 19 1939  
 Last saw him alive on Jan - 18 1939. Death is said to have occurred on the date stated above, at 10:20 a.m.  
 The principal cause of death and related causes of importance were as follows:

Prematurity  
15 1/4  
10

Other contributory causes of importance:  
No cause known

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury   
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?   
 If so, specify \_\_\_\_\_

(Signed) A. L. Cantrill, M. D.  
 (Address) Macon Mo.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 10

District File Number 10-39-112

Date Filed FEB 8 1939

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**