

13-40
7-39

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7371
Registrar's No. _____

MAR 17 1941
Registration District No. 449

Primary Registration District No. 4267

3
1
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Laclade
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community _____
years, months or days)

3. (a) PRENT FULLNAME Leo Patric Gary
3. (b) If veteran, name war _____
3. (c) Social Security No. 480-14-1129

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Loretta Carey
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Sept 23 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 4 22 _____ hr. _____ min.

9. Birthplace Manila Iowa /
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name John Carey

13. Birthplace Memphis Penn /
(City, town, or county) (State or foreign country)

14. Maiden name Mary McMahon

15. Birthplace Dont Know 9
(City, town, or county) (State or foreign country)

16. (a) Informant Loretta Carey
(b) Address Manila Iowa

17. (a) Removal (b) Date thereof 2/18/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Manilla Iowa

18. (a) Signature of funeral director [Signature]
(b) Address Lebanon Mo

19. (a) Ms-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Laclade 53
(c) City or town Lebanon /
(If outside city or town limits, write "RURAL") 2
(d) Street No. _____ (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 15
year 1941 hour 1 A. M. minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____ 1941 to _____ 1941
that I last saw him alive on 2/14/41
and that death occurred on the date and hour stated above.

Immediate cause of death:
Pneumonia 6 days
Influenza 2-4 days
Brain Tumor
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature [Signature] (M. D. _____)
Address Lebanon Date signed 2/15/41

RECEIVED

District Health Officer No. 7,

District File Number 3-41-544

Date Filed 3-13-41

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.....

Myself
....., Registered Apprentice No.....
working under my personal supervision.

Signed *W.E. Halman*

Licensed Embalmer No. *4107*

P. O. Address *Lebanon 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.