

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

40621
 Do not use this space.

1. PLACE OF DEATH
 (a) County Ray Registration District No. 7
 (b) Township Richmond Mo Primary Registration District No. 2 Registered No.
 (c) City Comden (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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.

2. PRINT FULL NAME Samuel Heever
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 14 - 1893

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	55	10	21	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio
 13. NAME Wm. Heever
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER
 15. MAIDEN NAME Belle Doughan
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Comden Mo DATE June 7 1939

19. FUNERAL DIRECTOR (ADDRESS) J. J. Matthews Richmond Mo

20. FILED Dec 2 1939 Manuel Mettel Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 5 1939

22. I HEREBY CERTIFY, That I attended deceased from 5-2 1939 to 5-5 1939
 I last saw him alive on 5-5 1939 Death is said to have occurred on the date stated above, at m.
 The principal cause of death and related causes of importance were as follows:
apoplexy Date of onset 5-5-39
Brain Pneumonia Date of onset 5-5-39
 Other contributory causes of importance

Name of operation Date of
 What test confirmed diagnosis? Phy Ex 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? No
 If so, specify
 (Signed) J. J. Matthews M. D.
 (Address) Richmond 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.

APR 5 1948

STATEMENT BY LICENSED EMBALMER

I, J. H. Brothers, Licensed Embalmer No. 2001

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by..... Registered Apprentice No.....

working under my personal supervision.

Signed Brother James Lane
J. H. Brothers
Licensed Embalmer No.....

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

40621
Do not use this space.

1. PLACE OF DEATH

(a) County Ray Registration District No. 739
 (b) Township Camden Primary Registration District No. 2974 Registered No. _____
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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.

2. PRINT FULL NAME Samuel Leaver

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Miss Bell Leaver

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-14-1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 - 10 - 21

OCCUPATION

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.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER

13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Mr. Russell Leaver
Richmond Mo

17. INFORMANT (ADDRESS)
Beet 1939 Mammoth

18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS)
Beet 1939 Mammoth

20. FILED Beet 1939 Mammoth
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 5 19 59

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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) Thos. F. Cook, M. D.
 (Address) Richmond Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CANCELED OR DESTROYED IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

