

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

Do not use this space.

15220

2089

File No. _____
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kaw Primary Registration District No. _____
City Kansas City (No. St. Luke's Hosp.)

2. FULL NAME

Mary Charlene Leipard
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) Bosworth Mo.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 18, 1915

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
12 0 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Scholar
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

Bosworth Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER

Louis Leipard

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Bosworth Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Elsie Hubbard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Carroll Mo.
(STATE OR COUNTRY)

PARENTS

14. INFORMANT Louis Leipard
(Address) Bosworth, Mo.

15. FILED 5/21/27 M. M. Crow
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 19 27

17. I HEREBY CERTIFY, That I attended deceased from May 18th, 1927, to May 20, 1927 that I last saw her alive on May 20, 1927, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Medullary Collapse - due to increased intracranial pressure from rupture of Hemorrhagic meningitis
(duration) yrs. 2 mos. 17 ds.

CONTRIBUTORY (SECONDARY) Hemorrhage from rupture of Meningeal Arteries
yrs. _____ mos. 4 ds.

18. WHERE WAS DISEASE CONTACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? refused

WHAT TEST CONFIRMED DIAGNOSIS? Examination of brain & spinal fluid
(Signed) M. W. C. Biller M. D.

5/22, 1927 (Address) 1316 Killebuck St., Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bosworth, Mo. DATE OF BURIAL May 21 19 27

20. UNDERTAKER A. H. Newcomer's Sons ADDRESS K. C. 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.

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Clerk of Vital Statistics,
Board of Health,
City.

Dear Sir:

Your inquiry regarding the cause of death of Mary Charlene Leopard on May 20, 1927, at Kansas City, Mo., was received yesterday.

You ask for the original location of the tumor and whether or not it was malignant. This I am unable to answer because of the fact we were refused an autopsy and the history of the case was not exacting enough to verify your inquiry.

However, the patient was in deep coma during most of the thirty-six hours under our observation before death. Physical and neurological examination evidenced possibility of a neoplasm in the posterior fossa. The spinal fluid was hemorrhagic, but no organisms were obtained. Ophthalmoscopic examination revealed retinal hemorrhages and choked discs.

I regret very much my inability to obtain a postmortem examination both because of our interest in the case and secondly to make satisfactory answer to your question.

I remain,

Yours very sincerely,

M. L. Dille M.D.
sent to Dr. Hoag

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requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate:

Name: Mary Charlene Lipard

Who died at: Kansas City, Mo. on May 20, 1927,

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Medullary collapse, - Due to increased intracranial pressure from Neoplasm or hemorrhagic meningitis
Contributory: Haemorrhage from neoplasm or meninges.

Where was disease contracted? _____

Did operation precede death? _____ Date of _____

What test confirmed diagnosis? _____

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