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

Do not use this space.

30655

File No. .....
Registered No. 3906

1. PLACE OF DEATH
County Jackson
Township Kaw
City Kansas City (No. General Hospital St. ..... Ward)
Registration District No. .....
Primary Registration District No. .....

2. FULL NAME John Leonard
(a) Residence. No. 515-E 9 St., 7 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) No data

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
Abt	76			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Auto Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Italy

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT Record Clerk
(Address) General Hospital

15. FILED 9/24 28 19 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 20 1928

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred, on the date stated above, at 3 P.M. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral
Hemorrhage
Stroke
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Chronic Nephritis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Hal Gaybright M. D
9/30, 19 28 (Address) Deputy Coroner

*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 St. Mary's
DATE OF BURIAL Sept 25 1928

20. UNDERTAKER R. V. Lindsey & Sons Kans City
ADDRESS Kans City, 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD