

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

Do not use this space.

6855

**1. PLACE OF DEATH**

County.....Jackson..... Registration District No.....399  
Township.....Kaw..... Primary Registration District No.....100?  
City.....Kansas City..... (No. 412 West 62nd Street.....

File No.....  
Registered No. 1022  
St..... Ward)

**2. FULL NAME** Annie Lewis Leonard

(a) Residence. No. 412 West 62nd Street St., W Ward. (If nonresident, give city or town and State)  
(Usual place of abode)

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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 12, 1852

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	76	11	16	

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

9. BIRTHPLACE (CITY OR TOWN) Cedar Rapids  
(STATE OR COUNTRY) Iowa

10. NAME OF FATHER Wilburt Luther Lewis

11. BIRTHPLACE OF FATHER (CITY OR TOWN) New York  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Emily Coffman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Circleville  
(STATE OR COUNTRY) Ohio

14. INFORMANT Mrs Fred C. Hanson  
(Address) #12 West 62nd St

15. FILED 3/1, 1929 M. M. Crowl REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feby. 28, 1929

17. HEREBY CERTIFY, That I attended deceased from Jan 26, 1929, to Feb 28, 1929, that I last saw her alive on Feb 28, 1929, and that death occurred, on the date stated above, at 2:10 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Central Abscess  
70.1 V  
115 B (duration) 1 yrs. 1 mos. 0 ds.  
CONTRIBUTORY alveolar infection  
(SECONDARY) (duration) 1 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) E. A. Burchardt, M. D.

3/1, 1929 (Address) 3346 Summit.

\*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 Lawrence, Kansas DATE OF BURIAL 3/2 1929

20. UNDERTAKER Stuever M. O'Brien ADDRESS 3235 Hillham Place

235  
2  
2  
2

3-5 P.M.

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County \_\_\_\_\_ Registration District No. 399  
 Township \_\_\_\_\_ Primary Registration District No. 1022  
 City St. City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Bernie Lewis Leonard  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED wid  
(write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (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)

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

14. INFORMANT (Address) \_\_\_\_\_

15. FILED 11/3/29 am. m. Corwin  
 REGISTRAR am

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 1929

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 \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Cerebral Abscess  
Metastatic from tooth socket.  
from tubercles (duration) yrs. mos. ds.  
 CONTRIBUTORY Alveolar infection  
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) \_\_\_\_\_, M. D.  
 . 19 (Address) \_\_\_\_\_

\*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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**SUPPLEMENTARY**

CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
 REGISTRAR ALL NOT RECEIVE.

5-6855