

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

Do not use this space
14672
Cover
File No. _____
Registered No. *1717* St. _____ Ward)

1. PLACE OF DEATH
County *Jackson* Registration District No. **399**
Township *Lead* Primary Registration District No. *1002*
City *Kansas City* (No. *2206 Harrison*) St. _____ Ward _____

2. FULL NAME *Leonard Anderson*
(a) Residence No. *2206 Harrison* 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 *Male* 4. COLOR OR RACE *Col.* 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) *Unknown*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 52

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

9. BIRTHPLACE (CITY OR TOWN) *Harvey, Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Nels Anderson*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *No Data*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *No Data*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *No Data*
(STATE OR COUNTRY)

14. INFORMANT *Mrs Mary Smith*
(Address) *2206 Harrison*

15. FILED *4/10, 1929 M. M. Brown*
REGISTRAR *Asst*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-9-29*

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 _____ A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Embolism of Lung
12 1/2 hrs
_____ (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *12 1/2 hrs*
_____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS *Autopsy*

(Signed) *Dr. [Signature]* M. D.

_____ 19____ (Address) *2206 Harrison*

*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 *Maple Hill Cem* DATE OF BURIAL *4/12 1929*

20. UNDERTAKER *Simmons & Son* ADDRESS *K.C. Mo*

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

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.

31-1-237

TO: SAC, NEW YORK (100-100000) FROM: SAC, PHOENIX (100-100000)

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

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