

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

27671  
3360

**1. PLACE OF DEATH**

County Jackson Registration District No. 109  
 Township Kaw Primary Registration District No. 02  
 City Kansas City (No. 69th & Prospect) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Frank Loncar, Jr.

(a) Residence. No. 5537 Tracy St. 15 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****MEDICAL CERTIFICATE OF DEATH**

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

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 8/5 1929

**17. I HEREBY CERTIFY,** Deputy Coroner that I attended deceased from \_\_\_\_\_

\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_, and that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

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

Katie Loncar**THE CAUSE OF DEATH\* WAS AS FOLLOWS:****6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Oct. 16, 1895

**7. AGE** YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
33 9 19

3rd degree burn over entire body.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. fireman  
 (b) General nature of industry, business, or establishment in which employed (or employer).  
 (c) Name of employer Fire department K C. Mo

**CONTRIBUTORY (SECONDARY).** Apoplexian while working as fireman for city of K.C. Mo.

**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?

(Signed) Stanley M. Haack, M. D.8/5 1929 (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.

**9. BIRTHPLACE (CITY OR TOWN)** Hamburg  
 (STATE OR COUNTRY) H Pennsylvania

**10. NAME OF FATHER** Frank M. Loncar

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**  
 (STATE OR COUNTRY) Don't know

**12. MAIDEN NAME OF MOTHER** Don't know

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**  
 (STATE OR COUNTRY) Don't know

**14. INFORMANT** Mrs. Katie Loncar  
 (Address) 5537 Tracy

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** St. Marys Cemetery **DATE OF BURIAL** 8-8 1929

**15. FILED** 8/5 1929 M. M. Crowe  
 REGISTRAR

**20. UNDERTAKER** R. V. LINDSEY & SONS, Inc **ADDRESS** K.C. Mo



**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 Jackson

Registration District No. 399

File No. \_\_\_\_\_

Township W. 1st

Primary Registration District No. 1012

Registered No. 9360

City Marion City

(No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

H. Frank 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**

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)**

October 16, 1897

**7. AGE**

YEARS

MONTHS

DAY

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

31

9

19

**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

9/5 19 29 M. M. Crowe

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Aug 5 19 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 \_\_\_\_\_ m.

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

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH 27691

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

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**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. CAUSAL PHYSICIANS SHOULD STATE EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. THIS STATEMENT MAY BE PROPERLY CLASSIFIED.

SUPPLEMENTARY

S-27671