

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

Do not use this space.

1139

1. PLACE OF DEATH

County Jackson Registration District No. 300
 Township KAW Primary Registration District No. 300
 City Kansas City (No. General Hospital) St. Ward)

File No.
 Registered No. 126

2. FULL NAME

(a) Residence. No. 1023 1/2 West 17th St. St. 4 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
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Della R. Leighton

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
about 60				

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Clerk
 (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) Mo.

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 Coverman's Record
 (Address) Kansas City, Mo

15. Jan 10, 19 30 M. M. Brown
 FILED REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-7 1930

17. I HEREBY CERTIFY, That I attended deceased from.....
Deputy Coroner
 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 hemorrhage
62 H
67
 (duration) yrs. mos. ds.
 CONTRIBUTORY Artery sclerosis
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED.....

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy
 (Signed) Shanty M. Hall M. D.
17, 1930 (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 Mt. Hope Cemetery DATE OF BURIAL Jan. 11, 19 30

20. UNDERTAKER R. V. Lirdsey & Sons, Inc 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.

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