

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

Do not use this space.

1. PLACE OF DEATH

County.....Jackson..... Registration District No. 369
Township.....Kaw..... Primary Registration District No. 1003
City.....Kansas City..... (No. 4023 Tracy)..... St. _____ Ward _____

File No. 16527
Registered No. 2018

2. FULL NAME

Ella Leishman
(a) Residence, No. 4023 Tracy..... 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Alex Leishman</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 10, 1865</u>				
7. AGE	YEARS <u>67</u>	MONTHS <u>6</u>	DAYS <u>0</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>At home</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....			
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Chambersburg Pennsylvania</u>			
	13. NAME <u>Isadore Stambaugh</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Chambersburg Pennsylvania</u>			
MOTHER	15. MAIDEN NAME <u>Kate Coonkleman</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Chambersburg Pennsylvania</u>			
17. INFORMANT <u>Alex Leishman</u> (ADDRESS) <u>4023 Tracy</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Tobey's Park</u> DATE <u>5/12/33</u>				
19. UNDERTAKER (ADDRESS) <u>Stine & Mc Cleary 3235 Bellcham Plaza</u>				
20. FILED <u>May 10 1933</u> <u>M. M. Crider</u> Registrar.				

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 10 1933

22. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1932, to May 2, 1933
I last saw her alive on May 2, 1933 Death is said to have occurred on the date stated above, at..... A. m. 8:40
The principal cause of death and related causes of importance were as follows:
Apoplexy Left Hemisphere - pleural effusions - embolism
Other contributory causes of importance:
hypertension
Date of onset 20/29/32

Name of operation..... Date of.....
What test confirmed diagnosis Physiocal & Path Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify.....
(Signed) Robert Mc Cleary M. D.
(Address) 1024 Professional Bldg

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.

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Dr Mc. [unclear]
Professional Bldg. Ev. 2892