

Aug 20 1935

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

Do not use this space.

20020

2394

1. PLACE OF DEATH
 48 County Jackson Registration District No. _____
 10 Township Kan Primary Registration District No. _____
 9 City Kan City (No. General Hospital) St. _____ Ward _____

2. FULL NAME J. H. L. Ledy
 (a) Residence, No. Jackson County, Home Ward _____
 (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 Male 4. COLOR OR RACE White 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 76

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

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 _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

FATHER 13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) None

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Greenlawn DATE July 5 1935

19. UNDERTAKER (ADDRESS) W. B. Bergman
K 6 info

20. FILED 7-5 1935 M. M. Crowe
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/27/35 1935

22. I HEREBY CERTIFY that I attended deceased from _____, 19____
 I last saw _____ alive on _____, 19____ Death is said
 to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Myocardial infarction
Chronic hypertension
coronary atherosclerosis
 Date of onset _____

Other contributory causes of importance:
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Name of operation _____ Date of _____
 What test confirmed diagnosis _____ Was there an autopsy? _____

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?
 If so, specify _____
 (Signed) _____, M. D.
 (Address) _____

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.

