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.

OCT 30 1935

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.: 399 — File No.: 32749

Township: ~~Kaw~~ — Primary Registration District No.: [illegible] — Registered No.: [illegible]

City: Kansas City (No. 3421 Cypress Avenue St. Ward)

2. FULL NAME: Joseph B. SLEIGHTHOLM

(a) Residence, No. 3421 Cypress Avenue St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) Leona D. Sleightholm

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 5th, 1879

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	56	---	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Clerk

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Railroad

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation 12

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

FATHER

13. NAME William Sleightholm

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

MOTHER

15. MAIDEN NAME Isabella Sanderson

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

17. INFORMANT (ADDRESS) Jack Sleightholm (brother) K. C. Kansas.

18. BURIAL, ~~CREMATION, OR REMOVAL~~ PLACE Forest Hill DATE 10/14/35, 19

19. UNDERTAKER (ADDRESS) Mellody - McGilley K. C. Mo.

20. FILED 10-14, 1935 M. M. Crowe asst. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/9/35, 19

22. I HEREBY CERTIFY: That I attended deceased from [illegible], 19 to [illegible], 19

I last saw h[illegible] live on 8 [illegible], 19 Death is said to have occurred on the date stated above, at [illegible] m.

The principal cause of death and related causes of importance were as follows:

Primary sclerosis

Chronic fibrous myocarditis

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

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) [illegible], M. D.

(Address) [illegible]