V. S. No. 2
M—11-10-39
v. 5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9778

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. ~~1212~~

1. PLACE OF DEATH:

(a) County Jackson.
(b) City or town Kansas City.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days. (Specify whether
In this community Unknown.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Jackson.
(c) City or town Kansas City.
(If outside city or town limits write "RURAL")
(d) Street No. 2217 East 68th Terrace.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 33 years years.

3. (a) PRINT FULL NAME John McLeod, 243

3. (b) If veteran, name war No.
3. (c) Social Security No. No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married.
6. (b) Name of husband or wife Carrie L. McLeod.
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased March (Month) 4 (Day) 1875 (Year)

8. AGE:

Years	Months	Days	If less than one day
65	0	12	hr. min.

9. Birthplace Scotland, (City, town, or county) 4 (State or foreign country)
10. Usual occupation Teacher Manuel Training Hi
11. Industry or business x

FATHER
12. Name John McLeod, 4
13. Birthplace Scotland, (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ~~Margaret Gallow,~~
15. Birthplace Scotland (City, town, or county) 11 (State or foreign country)

16. (a) Informant Dr. John McLeod.
(b) Address 9 East 67th St., K. C., Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-40 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington.
18. (a) Signature of funeral director Stine & McClure.
(b) Address 3235 Gillham Plaza, K. C., Mo.
19. (a) 3-18-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16th, year 1940 hour 11:55 minute P. M.

21. I hereby certify that I attended the deceased from Aug 18, 1925, to Mar 17, 1940 that I last saw him alive on Mar 16, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia — Duration 10 days
Due to Bilat Pyonephrosis — not known
Due to 1 23 h.
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature N. F. Oberblad (M. D. or other)
Address 1530 Prof. Bldg. Date signed Mar 18 1940

(Licensed Embalmer's Statement on Reverse Side)

Dr. ~~Schulblad~~ Eckenblad
1530 Prof.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed S. Fullen

Licensed Embalmer No. 1415

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.