

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1729

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 914 Union Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Leander G HORTON 635

3. (b) If veteran, Spanish name war American War. 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Unknown

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 4th, 1862
(Month) (Day) (Year)

8. AGE: Years 77 Months 7 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None 0

11. Industry or business _____

12. Name Unknown 9

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hospital Records.

(b) Address St. Joseph Hospital.

17. (a) Rem oval (b) Date thereof 4/23/40
(Burial, cremation, or removal) (City or town) (Day) (Year)

(c) Place: burial or cremation Wadsworth Kansas

18. (a) Signature of funeral director Melody-McGilley

(b) Address K. C. Mo.

19. (a) April 23, 1940 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15
year 1940 hour 4:20 minute 8 M.

21. I hereby certify that I attended the deceased from April 13
1940, to April 15, 1940;
that I last saw him alive on April 15, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Starvation -
lack of food Duration months
Due to uremia - Chr. nephritis

Due to Pneumonia -
Chr. Passive Congestion of lung
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: 154 101
Of operations _____
Of autopsy Hydrocephalus, myocarditis,
hepatitis,
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?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature M. F. Pittman (M. D. or other)
Address 830 Professional Bldg. Kansas City Date signed April 15 1940

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.....

Licensed Embalmer No..... 2999

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 1728

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Leander G. Horton

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, widowed, married, divorced <u>Unknown</u>
6. (b) Name of husband or wife _____	6. (c) Age of husband or wife if alive _____ years	

7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE: Years <u>77 yrs.</u>	Months _____	Days _____	If less than one day hr. _____ min. _____
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9. Birthplace (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
 13. Birthplace (City, town, or county) _____ (State or foreign country) _____
 14. Maiden name _____
 15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. 914 Union Ave. (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15th year 1940 hour _____ minute _____ M.

21. I, hereby certify that I attended the deceased from _____, 19____ to _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Starvation (Lack of Food)

Due to Uremia - Chronic Nephritis

Due to Pneumonia, Neither Broncho or lobar
Chronic passive cong. of lung

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Actual food privation
not due to disease
or physical condition

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature O. F. Pittam (M. D. or other) _____

*Address _____ Date signed _____

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

14016

STATEMENT TO

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.....

Licensed Embalmer No.....

P. O. Address.....

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.