

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2498

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution 7 days
(Specify whether
In this community 40 yrs
years, months or days)

3. (a) PRINT FULL NAME PHIL LEFLER 146

8. (b) If veteran, name war --- 3. (c) Social Security No. None

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased Oct. 19th 1863
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 26 If less than one day hr. min.

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

10. Usual occupation None 7

11. Industry or business None 9

12. Name Unknown
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 Mrs. Dora Lefler
(b) Address 1004 West 21st St.

17. (a) Burial (b) Date thereof 6-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Green Lawn Cem. K.C., Mo.

18. (a) Signature of funeral director W. A. Lohmeyer
(b) Address City mortician

19. (a) June 28, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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. 1004 West 21st St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14th
year 1940 hour 2 minutes 50 P. M.

21. I hereby certify that I attended the deceased from June 7th 1940 to June 14th, 1940

that I last saw him alive on June 14th, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Terminal bronchopneumonia; Uremia; Prostatic abscess; Chronic vascular nephritis;

Due to Gen'l. atherosclerosis with encephalomalacia

Due to 31

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

Major findings: Of operations _____
Of autopsy See above

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 Dr. De Maria (M. D. or other)
Address Supt. K.C. Gen. Hospital, K.C., Mo. Date signed _____

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

MOTHER FATHER

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

FEB 17 1953

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 Wm A. Lohmeyer
Licensed Embalmer No. 30849

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.