No. 2
13-40
7-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30866

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3429

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:
Kansas City General Hosp. #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 Minutes (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 929 Quindaro Blvd
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME IRWIN EUGENE LETCHER

3. (b) If veteran, name war No

3. (c) Social Security No. 487-07-3971

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Helen L.

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

7. Birth date of deceased April 23, 1915
(Month) 15 (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
25	4	7	..... hr. ..... min.

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

10. Usual occupation Shipping Clerk

11. Industry or business Cowden Manufacturing Co.

FATHER
12. Name Roy C. Letcher
13. Birthplace Atchinson Kansas
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Nellie Morasch
15. Birthplace Kansas City Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Harriet Eisman
(b) Address 1008 Brown Ave. K.C.Kans.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/40 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope

18. (a) Signature of funeral director Geo. H. Long
(b) Address 10th St & Barnett Ave. K.C.K.

19. (a) Sept. 2. 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day 8.30.40
year ..... hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from 3:15 A.M. ..... 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 Hemo peritoneum

Due to Rupture of the liver

Due to Automobile traumatism

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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) Accident
(b) Date of occurrence 8-30-40
(c) Where did injury occur? K.C. (City or town) Mo (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 5

23. Signature Arthur M. Mahler (M. D. or other)
Address K.C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

210 m
9.5

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 Blaine E. Weelent

Licensed Embalmer No. 4075

P. O. Address 2332 Moniton

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

If this body is not embalmed, fact should be so stated above.

No. 2B
2-21-40
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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. 2

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 3429

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K. C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Irwin E. Letcher

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced W

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 | Months | Days | If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

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

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) 19/16/40 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. 30 day 40
year ..... hour ..... minute ..... M.

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

Immediate cause of death Hemoperitoneum
Rupture of liver
Due to Auto. trauma
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)
210 M
7 2

Major findings:
Of operations .....
Of autopsy .....

Duration

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) Accd -
(b) Date of occurrence 8-30-40
(c) Where did injury occur? K. C. Mo -
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Collision of automobiles
(Specify type of place)
While at work? No (e) Means of injury Auto acc

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....