V. S. No. 2
DM—11-10-39
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 34508

Registrar's No. 4024

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

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:
3205 McGee Street 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ------ (Specify whether
In this community 81 Years
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")

0 (d) Street No. 3205 McGee Street
(If rural, give location)

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

3. (a) PRINT FULL NAME Mr. Thomas H. Leary

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mrs. Fredrica Leary

6. (c) Age of husband or wife if alive Won't Tell

7. Birth date of deceased April (Month) 4 (Day) 1859 (Year)

8. AGE:

Years	Months	Days	If less than one day
81	6	14	hr. min.

9. Birthplace Kansas City (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Carriage Builder 5

11. Industry or business Retired 5

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

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

16. (a) Informant Mrs. Fredrica Leary
(b) Address 3205 McGee Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21, 1940 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Mt. St. Mary's Cemetery

18. (a) Signature of funeral director O. W. Newcomer's Sons
(b) Address 1401 Brush Creek Blvd.

19. (a) 10-20-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 18th
year 1940 hour 11 minute 30 A. M.

21. I hereby certify that I attended the deceased from
About 2 yrs, 19__, to Oct 18, 1940
that I last saw him alive on Oct 17, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Cerebral Myelacia

Due to Arteriosclerosis

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)
(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 Dr. John O. Sturmer (M. D. or other)
Address 140 [illegible] Date signed

(Licensed Embalmer's Statement on Reverse Side)

Hd 2 Bryant Bldg.
2-6

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 H. O. Newcomer Jr

Licensed Embalmer No. 4045

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.