

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH: **Jackson**
 (a) County _____
 (b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7 days**
(Specify whether years, months or days)
 In this community **about 25 yrs**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **JOHN LEONARD**
 3. (b) If veteran, name war **V**
 3. (c) Social Security No. **V**

4. Sex **Male** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **single**
 6. (b) Name of husband or wife **V**
 6. (c) Age of husband or wife if alive **V** years
 7. Birth date of deceased: **not known**
(Month) (Day) (Year)

8. AGE: **about 25**
 Years Months Days If less than one day
hr. min.

9. Birthplace **not known** **9**
(City, town, or county) (State or foreign country)

10. Usual occupation **Not known** **9**

11. Industry or business **Not known** **9**

12. Name **Not known** **9**

13. Birthplace **Not known** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Not known**
 15. Birthplace **Not known**
(City, town, or county) (State or foreign country)

16. (a) Informant **Reising Mortuary**
 (b) Address **Kansas City, Kans**

17. (a) **Burial** (b) Date thereof **12/24/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **mt. Calvary K.C. Mo**

18. (a) Signature of funeral director **J. A. Reising**
 (b) Address **701 W. 13th St. K.C. Mo**

19. (a) **2-23-40** (b) **H. M. Grove**
(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 limit: write "RURAL")
 (d) Street No. **614 Main St.**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **23rd**
 year **1940** hour **12** minute **20 A.M.** M.

21. I hereby certify that I attended the deceased from **12-16-40**, 19, to **12-23-40**, 19;
 that I last saw him alive on **12-23-40**, 19,
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**

Due to **820**

Due to _____

Other conditions **Bronchial pneumonia**
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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?
3 6/1

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

23. Signature **Dr. R. Thon** (M, D, or other) _____
 Address **Med. Dir. K.C. Gen. Hospital, K.C. Mo.** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.