

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41503**
6896
Registrar's No.

Registration District No. **399** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kaw**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **2642 East 30th.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **43 Yrs.**
In this community **43 Yrs.**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **2642 East 30th.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Joseph Oe J. Lea**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **Wh.** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Charlotte C. Lea** 6. (c) Age of husband or wife if alive **68** years
7. Birth date of deceased **Aug. 10 1864**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 **4** **12** hr. min.

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

10. Usual occupation **Contractor**

11. Industry or business _____

12. Name **John C. Lea**
13. Birthplace **Unknown Tenn.**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Hicks**
15. Birthplace **Unknown Tenn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Charlotte Lea**

(b) Address **2642 East 30th.**

17. (a) **Burial** (b) Date thereof **12-24-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill**

18. (a) Signature of funeral director **Eylar Funeral Home**
(b) Address **K.C. Mo.**

19. (a) **12-24-40** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec** day **23**
year **1940** hour **3** minute **5** M.

21. I hereby certify that I attended the deceased from **June 1940**
to **July 1940**
that I last saw him alive on **July 22**
and that death occurred on the date and hour stated above.

Immediate cause of death
Subacute Coma
Arachnoiditis
Due to **Carcinoma of Liver**
Due to **H/O**
Other conditions
(Include pregnancy within 3 months of death)

Duration
5 days
37 days
2 yrs

Major findings:
Of operations _____
Of autopsy _____

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 **M. M. Crowe** (M. D. or other) _____
Address **1329 Indian St.** Date signed **12/23/40**

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

MAR 20 1924

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..... *Chas Wilks*

Licensed Embalmer No. *2644*

P. O. Address..... *1800 Pinewood*

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, fact should be so stated above.