

JAN 8 1941
Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kan City, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 months
Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Leodia J. Perry

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex fe 5. Color or race w 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Jan 19th 1898-1897
(Month) (Day) (Year)

8. AGE: Years 43 Months 11 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation office clerk

11. Industry or business _____

MOTHER FATHER
12. Name Hugh Perry
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Mary Michael Mabry
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Harper
(b) Address 2204 Van Buren

17. (a) Burial (b) Date thereof 12/30/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hill Cemetery

18. (a) Signature of funeral director Snow Myer
(b) Address 2315 Linnwood

19. (a) 12-30-40 (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 Kan City, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 2418 E 14th
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 26 year 1940 hour _____ minute 19 30 PM

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

Immediate cause of death
Cerebral Ancephalomalacia & hemorrhage
Hypertensive myocardial
Due to _____
Other conditions (include pregnancy within 3 months of death) 49.5

Duration

PHYSICIAN

Major findings: Of operations _____
Of autopsy _____
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 Russell [unclear] (M. D. or other) _____
Address _____ Date signed _____

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. 2
working under my personal supervision.

Signed Ray E Snow
Licensed Embalmer No. 2566
P. O. Address 2315 Lincoln

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

If this body is not embalmed, above space should be left blank.