

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County M. 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:
301 North Lawn Avenue
(If not in hospital or institution, write street number or location)

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

In this community 17 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **48**

(c) City or town Kansas City **3**
(If outside city or town limits, write "RURAL")

(d) Street No. 301 North Lawn Avenue **8**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) **(No)**

If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Amanda Leasa

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife William Leasa

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

7. Birth date of deceased: June 25 1852
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>90</u>	<u>0</u>	<u>6</u>	hr. _____ min.

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

10. Usual occupation None

11. Industry or business At Home

MOTHER FATHER { 12. Name Unknown Gibson **9**

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. D. S. Jones

(b) Address 301 North Lawn

17. (a) Burial (b) Date thereof July 3, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs, Mo.

18. (a) Signature of funeral director D. H. Newton

(b) Address 1401 Brush Creek Blvd.

19. (a) 7-2-42 (b) M. B. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1
year 1942 hour 8:24 minute 45 P.M.

21. I hereby certify that I attended the deceased from June 15 to July 1, 1942
that I last saw her alive on July 1, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage **3 days**

Due to Old age

Due to 830

Other conditions (Include pregnancy within 3 months of death)

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) No

(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 D

23. Signature P. L. St. Clair (M. D. or other) _____
Address _____ Date signed _____

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

Dr. St. Clair
5-24-25

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..... *A. C. Newcomer Jr.*
Licensed Embalmer No. *4043*
P. O. Address *E. 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, fact should be so stated above.