

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **FILED JAN 24 1943**

Primary Registration District No. **1002**

Registrar's No. **17**

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:
1817 Norton
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **30 Years** (Specify whether 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")

(d) Street No. **1817 Norton** (If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **PHOEBE ELIZABETH LESLIE**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Fe.** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**

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

7. Birth date of deceased **Nov. 2, 1864**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	78	1	29	hr. _____ min.

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

10. Usual occupation **Homemaker**

11. Industry or business **None**

12. Name **Unknown**

13. Birthplace **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. R. E. Phillips**

(b) Address **1817 Norton**

17. (a) **Burial** (b) Date thereof **1-4-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elmwood Cemetery**

18. (a) Signature of funeral director **C. H. Blackman & Spn, inc**

(b) Address **Kansas City, Mo.**

19. (a) **1-4-43** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **1**
year **1943** hour **7** minute **10 A.** M.

21. I hereby certify that I attended the deceased from **July 1940** to **Jan 1 1942** that I last saw her alive on **Dec 31 1942** and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Pneumonia**
Copper Respir. Infection

Due to **Acute Pneumonia**

Due to **Acute Pneumonia**

Other conditions (If only pregnancy within 3 months of death)
Hypertension - 61

Major findings: **none**

Of operations **none**

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? **✓**
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **✓**

23. Signature **D. E. Edwards** (M. D. or other)
Address **4800 G. N. St.** Date signed **1/21/43**

Duration **6.00**
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

01

Handwritten notes on the right margin.

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 B. H. Blackman

Licensed Embalmer No. 2244

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, fact should be so stated above.