

FILED DEC 3 1943
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State File No. _____
Registrar's No. 4965

Registration District No. _____ Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
709 Washington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 3 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 709 Washington
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Homer Leach

3. (b) If veteran, name war Do not know 3. (c) Social Security No. Do not know

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Do not know
6. (b) Name of husband or wife Do not know 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: 1855
(Month) (Day) (Year)

8. AGE: Years 88 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Do not know (City, town, or county) (State or foreign country)

10. Usual occupation P

11. Industry or business _____

MOTHER FATHER { 12. Name Do not know
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Do not know
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Coroner Office

(b) Address Kansas City Mo.

17. (a) Kirkville Mo. (b) Date there Nov. 26 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirkville College Osteopathy

18. (a) Signature of funeral director Passantino Bros.

(b) Address Kansas City Mo.

19. (a) 11-25-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19
year 1943 hour 10 minute 45 a. M.

21. I hereby certify that I attended the deceased from _____ 19____;
Deputy Coroner
and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic Heart Disease.
Due to _____
Due to 93d
Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy Inspection & History

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? _____

23. Signature Do E. Walker (M. D. or other) _____
Address 237 N. Col Date signed 11/27/43

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

Park J. Rowe

Licensed Embalmer No. *2347*

P. O. Address *H. 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.