

FILED FEB 9 1944
42

Registration District No. _____ Primary Registration District No. **(1000)**

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

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community life
years, months or days)

3. (a) PRINT FULL NAME Ida Marie Leucht
3. (b) If veteran, name war _____ **3. (c) Social Security No.** 48 932

4. Sex Female **5. Color or race** White **6. (a) Single, widowed, married, divorced** Married
6. (b) Name of husband or wife William Leucht **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased April 27, 1872
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|----------|----------------------|
| | <u>71</u> | <u>9</u> | <u>7</u> | _____ hr. _____ min. |

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

10. Usual occupation Housewife

11. Industry or business Own home

MOTHER FATHER
12. Name Henry Zondler
13. Birthplace Germany
(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 William Leucht
(b) Address 2310 So. 19th St.

17. (a) Burial _____ **(b) Date thereof** Jan. 7, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ashland Cem.

18. (a) Signature of funeral director Clark Mortuary
(b) Address 5025 King Hill Ave.

19. (a) 1-7-44 **(b) Rose Heigoy**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
 (d) Street No. 2310 So. 19th St.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 4 year 1944 hour 8 minute 30 p. M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw her alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death
Intestinal obstruction 2 wks
Due to unknown
Due to _____
 Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
 Of operations _____
 Of autopsy _____

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 John J. [Signature] (M. D. or other)
Address Dr. Joseph M. [Signature] Date signed 1-6-44

Duration

PHYSICIAN

 Underline the cause to which death should be charged statistically.

Byrne

SEP 22 1944

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 *1/4/44*

Registered Apprentice No. _____

working under my personal supervision.

Signed *Emil Clark*

Licensed Embalmer No. *4235*

P. O. Address *St. Joseph*

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.