

V. S. No. 2
100M-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26897**
Registrar's No. **3414**

FILED SEP 7 1944/9

Registration District No. _____ Primary Registration District No. **1002**

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

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:
1308 Troost
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **Unknown** (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **1308 Troost**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **William Leslie**
3. (b) If veteran, name war **Unknown** 3. (c) Social Security No. **Unknown**
4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Unknown**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **18** year **1944** hour **2:10** minute **P.** M.
21. I hereby certify that I attended the deceased from **Regency Arms**, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
Aprox. 75 hr. min.

Immediate cause of death **Coronary arterio sclerosis**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **940**
Major findings: Of operations _____
Of autopsy **inspection & history**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace **Unknown** (City, town, or county) (State or foreign country)
10. Usual occupation **Unknown**
11. Industry or business **Unknown**
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 **Coroners Office**
(b) Address **Jackson County? mo.**
17. (a) Burial (b) Date thereof **8/21/44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Hope Cem.**
18. (a) Signature of funeral director **H. Tigerman & Sons**
(b) Address **K. C. Mo. T-6 Brown (V3)**
19. (a) **8-19-44** (b) **T-6 Brown (V3)**
(Date received local registrar) (Registrar's signature)

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 **D. E. Upsher** (M. D. or other) **MD**
Address **2302 a mckay** Date signed **8/19/44**

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.....

Did not Embalm

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

J. R. Pegg

..... Licensed Embalmer No.....

..... 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.