U. S. No. 2
100M—2-43
Rev. 5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 1 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1108

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 55

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: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Days
In this community 2½ 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.: 2916 Prospect 8
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Leonard Ross Fox
3. (b) If veteran, name war: World War 1
3. (c) Social Security No. 487-18-5541
4. Sex: Male D
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Cora M. Fox
6. (c) Age of husband or wife if alive: 56 years
7. Birth date of deceased: 7 (Month) 20 (Day) 1894 (Year)
8. AGE: Years 50 Months 5 Days 14 If less than one day hr. min.
9. Birthplace: Slater (City, town, or county) Missouri (State or foreign country) U
10. Usual occupation: Inspector Benson Mfg. Plant
11. Industry or business:
FATHER 12. Name: William O. Fox
13. Birthplace: Ohio (City, town, or county) (State or foreign country) 1
MOTHER 14. Maiden name: Sarah Wilson
15. Birthplace: Ohio (City, town, or county) (State or foreign country) 1
16. (a) Informant: Mrs. Cora M. Fox
(b) Address: 2916 Prospect
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-6-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Green Lawn
18. (a) Signature of funeral director: Mrs. C. L. Forster
(b) Address: Kansas City, Missouri
19. (a) 1-6-45 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 4th. year 1945 hour 10 minute A. M.
21. I hereby certify that I attended the deceased from Oct. 9, 1944 to Jan. 4, 1945; that I last saw him alive on January 4, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary occlusion, anterior	Immediate
Due to: Sinus tachycardia	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 940	

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):
(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: [illegible] (M. D. or other)
Address: 925 Argyle Bldg. K.C. Mo. Date signed 1-5-45

(Licensed Embalmer's Statement on Reverse Side)

Dr. D.M.Nigro

JAN 22 1915

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 Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address B.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.