

Registration District No. _____ Primary Registration District No. 3012

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs. 2 mos. 9 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Woodbury

(c) City or town Sioux City
(If outside city or town limits, write "RURAL")

(d) Street No. 2620 Terminal Drive
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 2

3. (a) PRINT FULL NAME Leonard Jacob Besch

3. (b) If veteran, name war World War II

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 29 1914
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>30</u>	<u>1</u>	<u>28</u>	hr. _____ min.

9. Birthplace Fullerton, Nebraska
(City, town, or county) (State or foreign country)

10. Usual occupation Farm work

11. Industry or business "

MOTHER FATHER

12. Name John Besch

13. Birthplace Luxembourg
(City, town, or county) (State or foreign country)

14. Maiden name Rose Treweiler

15. Birthplace Shelby County Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records, Veterans Administration, Excelsior Springs, Mo.

(b) Address _____

17. (a) Removal (b) Date thereof 2-26-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: of removal Sioux City, Iowa
(Burial or cremation)

18. (a) Signature of funeral director Herbert Hope
HERBERT HOPE

(b) Address Excelsior Springs, Mo.

19. (a) 2-26-45 Mrs. Sarah Richman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 26
year 1945 hour 4:30 minute A. M.

21. I hereby certify that I attended the deceased from December 17, 1943 to February 26, 1945;
that I last saw him alive on February 26, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, chronic far advanced, active, Duration unknown

Due to _____

Due to _____

Other conditions Tuberculosis, epididymitis, bilateral, severe, with draining sinus unknown
(Include pregnancy within 3 months of death.) PHYSICIAN

Major findings:
Of operations _____

Of autopsy NO AUTOPSY

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 C

23. Signature Ernest M. Tapp (M. D. or other) MD
ERNEST M. TAPP, Lt. Col. M.C. 2-26-45
Address Veterans Administration Date signed _____
Excelsior Springs, Mo.

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

3-9-45

JUL 28 1949

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

James A. Moles

Licensed Embalmer No.

3296

P. O. Address

Ex Spring 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.