

STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED OCT 24 1945  
Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1064

1. PLACE OF DEATH:  
(a) County Bucklman  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital No. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 34 yrs. 21 days  
(Specify whether  
In this community 38 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Bucklman  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME LEOLA MUNROE  
3. (b) If veteran, name war none  
3. (c) Social Security No. none

4. Sex male 5. Color or race Negro  
6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife none  
6. (c) Age of husband or wife if alive none years  
7. Birth date of deceased 4 - 7 - 1888  
(Month) (Day) (Year)

8. AGE: Years 57 Months 5 Days 18  
If less than one day hr. min.

9. Birthplace Secaucus, New Jersey  
(City, town, or county) (State or foreign country)

10. Usual occupation Common Laborer

11. Industry or business Common Laborer

12. Name Harrison Munroe

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

14. Maiden name Katie Munroe

15. Birthplace Bonnieville, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jessie Brooks

(b) Address 2706 Norton Ave. K. C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation Asylum Cemetery

18. (a) Signature of funeral director Quincy Son

(b) Address 1602 Madison

19. (a) 10-8-45 (Date received local registrar) (b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 9 day 25  
year 1945 hour 8 minute 20 P.M.

21. I hereby certify that I attended the deceased from 3-1-1943 to 9-25-1945  
that I last saw him alive on 9-25-1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchio-pneumonia  
Due to Enterocolitis

Due to Psychic ingestion of foreign body  
Other conditions unknown  
(include pregnancy within 3 months of death)

Major findings: Of operations None  
Of autopsy None

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 None

23. Signature J. H. Morrison (M. D. or other) \_\_\_\_\_  
Address State Hospital No. 2 Date signed 9-25-45

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

MOTHER FATHER

1728

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

**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.

*Body not embalmed*  
*Body 11*

Signed J. F. Ramsey

Licensed Embalmer No. 4081

P. O. Address 1602 Mississippi

**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.**