S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36261

FILED NOV 26 1945

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4726

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. MARY'S HOSPITAL O (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 1 WEEK (Specify whether

In this community 40 YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLAY 24

(c) City or town NORTH KANSAS CITY 3 (If outside city or town limits, write "RURAL")

(d) Street No. 440 EAST 45TH CRESTVIEW ADD. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME MR. FRED LEACH

3. (b) If veteran, name war No

3. (c) Social Security No. 707-07-6844

4. Sex MALE C

5. Color or race WHITE

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

6. (b) Name of ~~husband~~ or wife MRS. MARY AGNES LEACH

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased JUNE (Month) 11 (Day) 1887 (Year)

8. AGE: Years 58 Months 5 Days ~~5~~ 3 If less than one day ..... hr. ..... min.

9. Birthplace CAMERON (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation SWITCHMAN

11. Industry or business CHICAGO-BURLINGTON R.R.

FATHER
12. Name AL LEACH
13. Birthplace CAMERON (City, town, or county) MISSOURI O (State or foreign country)

MOTHER
14. Maiden name CAROLINE KELLER
15. Birthplace NEAR CAMERON (City, town, or county) MISSOURI O (State or foreign country)

16. (a) Informant MRS. MARY AGNES LEACH

(b) Address 440 EAST 45TH NO. KANSAS CITY MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV-17-1945 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ FLORAL HILLS CEMETERY

18. (a) Signature of funeral director D. N. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 11-18-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 14TH year 1945 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from 11-5-45, 19..., to 11-14-45, 19...; that I last saw him alive on 11-14-45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	7 days
Cerebral Embolus	10 days

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 83 b

Major findings:
Of operations

Of autopsy Bronchopneumonia
Encephalomyelocele

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 O

23. Signature Geo. C. Kearhofer (M. D. or other)

Address 301 E. 28th North Kansas City Mo Date signed 11-16-45

(Licensed Embalmer's Statement on Reverse Side)

Argyle Bldg

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 H. C. Newcomer Jr

Licensed Embalmer No. 4043

P. O. Address K. 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.