

S. No. 2  
M-5-43  
7. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23850**  
Registrar's No. **3919**

**FILED JUL 31 1946**

Registration District No. **149** 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:  
**General Hospital No. 10**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 mo. 2 days**  
(Specify whether years, months or days) **10 years**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Jackson 48**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **4121 Troost**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **Ben Liesling**  
3. (b) If veteran, name war **no** 3. (c) Social Security No. **492-18-5172**  
4. Sex **male** 5. Color or race **white**  
6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Suzelle V.** 6. (c) Age of husband or wife if alive **41** years  
7. Birth date of deceased **March 10, 1903**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **July** day **9** year **1946** hour **1** minute **40 P.**  
21. I hereby certify that I attended the deceased from **June 7**, 19 **46**, to **July 9**, 19 **46**  
that I last saw him alive on **July 9**, 19 **46**  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**43** **3** **29** hr. min.

Immediate cause of death  
**Subacute bacterial endocarditis**  
**confluent bronchopneumonia**  
**purulent meningitis**  
Due to

9. Birthplace **Green Bay Wisconsin**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Auto mechanic**  
11. Industry or business **Bill Sullivan Chev. Dealer**

Other conditions (Include pregnancy within 3 months of death) **9/12**  
Major findings: Of operations  
Of autopsy **See above**

MOTHER FATHER  
12. Name  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name  
15. Birthplace (City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant **Suzelle Liesling**  
(b) Address **4121 Troost**  
17. (a) **Burial** (burial, cremation, or removal) (b) Date thereof **7-11-46**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **Memorial Park**

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?

18. (a) Signature of funeral director **Melody Mc Silley**  
(b) Address **H. C. Mc**  
19. (a) **7-10-46** (Date received local registrar) (b) **Suzelle Holmes** (Registrar's signature)

23. Signature **Wm W Hart** (M. D. or other) **9-10-46**  
Address **Med. Dir. Gen'l Hosp.** Date signed

*Dr. Buckner*

**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

*Russell N. France*

Licensed Embalmer No.....

*4255*

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.**