

**FILED AUG 19 1946 STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_

Registration District No. 150

Primary Registration District No. 5672

Registrar's No. 109

**1. PLACE OF DEATH:**

(a) County Jackson  
(b) City or town Rural Prairie Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jackson County Home for aged 5  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 25 yrs  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City Mo. 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5445 Tracy 8  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ELIZABETH LEIBER

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W 2  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive ✓ years 1-1877  
7. Birth date of deceased 3-1-1877  
(Month) (Day) (Year)

8. AGE: Years 69 Months 3 Days 29 If less than one day hr. min.

9. Birthplace Wiem, Mo (City, town, or county) (State or foreign country)

10. Usual occupation unknown

11. Industry or business \_\_\_\_\_

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)

16. (a) Informant Jackson County Home Reside

(b) Address R.R. #4, Indep Mo

17. (a) Removal (b) Date thereof 7-2-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Calvary Hosp

18. (a) Signature of funeral director M B Smith

(b) Address 1111/46

19. (a) 11/46 (b) 11/46  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 30  
year 1946 hour 8:40 minute P M.

21. I hereby certify that I attended the deceased from June 26 1946 to June 30 1946  
that I last saw her alive on June 30 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations § 300  
Of autopsy \_\_\_\_\_

Duration

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury 0

23. Signature W. G. Green (M. D. or other) \_\_\_\_\_  
Address W. G. Green Date signed 7/1-46

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

MOTHER FATHER

**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 W.B. Longford  
Licensed Embalmer No. 3833  
P. O. Address Leis Summit

**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.**