

U.S. No. 2
 Form 5-43
 Rev. 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. **8984**
 Registrar's No. **975**

FILED MAR 21 1947
 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:
St Luke Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution... **11 days**
(Specify whether years, months or days)
 In this community... **10 yrs**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Jackson 48**
 (c) City or town... **Kansas City** **3**
(If outside city or town limits, write "RURAL")
 (d) Street No. **100 North Indiana** **8**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No) **0**
 If yes, name country.....

3. (a) PRINT FULL NAME **Leona Conard**
 3. (b) If veteran, name war **Mo**
 3. (c) Social Security No. **493-22-5472**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **March** day **3**
 year **1947** hour **6** minute **47 P.M.**
 21. I hereby certify that I attended the deceased from **February 20**
 19**47** to **3 March** 19**47**
 that I last saw him alive on **3 March** 19**47**
 and that death occurred on the date and hour stated above.

4. Sex **7/** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Hughes J. Conard**
 6. (c) Age of husband or wife if alive **45** years
 7. Birth date of deceased **May 3- 1914**
(Month) (Day) (Year)

Immediate cause of death... **Myeloid Leukemia.**
 Duration **?**
 Due to.....
 Due to.....
 Other conditions (Include pregnancy within 3 months of death) **740**

8. AGE: Years **32** Months **10** Days **6**
 If less than one day hr. min.

9. Birthplace **Lone Jack Mo 1**
(City, town, or county) (State or foreign country)
 10. Usual occupation **office**

MOTHER FATHER
 11. Industry or business **1**
 12. Name **Lee Thomas**
 13. Birthplace **Lone Jack Mo 0**
(City, town, or county) (State or foreign country)
 14. Maiden name **Viola Waters**
 15. Birthplace **Grafton Valley Mo 1**
(City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings:
 Of operations.....
 Of autopsy **same**
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Lee Thomas**
 (b) Address **Lone Jack Mo**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **3-5-47**
(Month) (Day) (Year)
 (c) Place: burial or cremation **Lone Jack Mo**
 18. (a) Signature of funeral director **H. B. Langford**
 (b) Address **Leis Summit**
 19. (a) **3-4-47** (Date received local registrar)
 (b) **Geraldine Holmes** (Registrar's signature)

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?
 23. Signature **Edward C. D. Smith** (M. D. or other) **MD**
 Address **St. Luke's Hosp** Date signed **3 March 1947**

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.....

Licensed Embalmer No..... 3833

P. O. Address..... Lee's 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.