

X47070

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

FILED MAY 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13537

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1805

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:
3626 1/2 Independence Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joyce Gill LeShure

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife.

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

7. Birth date of deceased 8 1 1929
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>17</u>	<u>8</u>	<u>18</u>	hr. min.

9. Birthplace: Kansas City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation School Girl

11. Industry or business Junior College

12. Name Lyle G. LeShure

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

14. Maiden name Velma Morrison

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

16. (a) Informant Mr. Lyle G. LeShure

(b) Address 409 South Oakley

17. (a) Burial (b) Date thereof 4-22-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address Kansas City, Missouri

19. (a) 4-21-47 (b) Sheldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City Oakley 3
(If outside city or town limits, write "RURAL") 8

(d) Street No. 409 South Oakley
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19th
year 1947 hour 11 37 minute A M.

21. I hereby certify that I attended the deceased from April 4, 1947, to April 19, 1947
that I last saw her alive on April 19, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Endocarditis Duration 2 mo

Due to

Due to

Other conditions 9/15
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy no

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?

(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 0

23. Signature Chas. Nelson (M. D. or other)

Address 3626 Independence Date signed

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 C. H. Wise

Licensed Embalmer No. 2520

P. O. Address TEO 2000

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.