

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:
3820 Troost
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 67 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Abraham Lebrecht
 3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Anna 6. (c) Age of husband or wife if alive 70 years
 7. Birth date of deceased November 16, 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>6</u>	<u>13</u>	<u>hr. min.</u>

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

10. Usual occupation retired butcher

11. Industry or business

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

16. (a) Informant Irving Feld
 (b) Address 46th. & Troost

17. (a) burial (b) Date thereof 6-1-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill
 18. (a) Signature of funeral director Carroll Davidson
 (b) Address 3024 Troost

19. (a) 5-30-47 (b) Geraldine 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 3
(If outside city or town limits, write "RURAL")
 (d) Street No. 3820 Troost
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 29
 year 1947 hour 9 minute 50 A.M.
 21. I hereby certify that I attended the deceased from Jan. 10 to May 9, 19 47
 that I last saw him alive on May 8, 19 47
 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral thrombosis Duration 6 wks. over 5 yrs.
 Due to arteriosclerosis, cerebral

Due to arteriosclerosis, cerebral
 Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations 838
 Of autopsy

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? no Means of injury no
 23. Signature Arnold V. Ames, M.D. (M. D. or other)
 Address 501 Plaza Medical Bldg Date signed 5/9/47
K. City, Mo

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.....

P. O. Address.....

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.

10. Usual occupation *Retired Butcher*
(City, town, or county) (State or foreign country)

11. Industry or business _____

MOTHER FATHER { 12. Name *Henry Lebrecht*

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

14. Maiden name *Rachel Leibstatler*

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

16. (a) Informant *Irving Feld*

(b) Address *46th & Troost ave.*

17. (a) *Burial* (b) Date thereof *6/1/47*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Rose Hill Cemetery*

18. (a) Signature of funeral director *Carroll Davidson*

(b) Address *3024 Troost ave.*

19. (a) *5-30-47* (b) *Sheldine Holmes*
(Date received local registrar) (Registrar's signature)

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

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) (Specify type of place)

While at work? _____ Means of injury _____

23. Signature *Amos Thomas MD* (M. D. or other) _____

Address *21 Perry St* Date signed *5/29/47*

Kitty New

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

Kathryn E. Davison

Licensed Embalmer No.

3648

P. O. Address:

A. 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.

10/14/20
10/14/20