

FILED FEB 17 1948

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 498

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. 1 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 days  
(Specify whether years, months or days)

In this community 24 years  
(Specify whether years, months or days)

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. 1407 E. 10 St. 1  
(If rural, give location) 0

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

3. (a) PRINT FULL NAME Sallie Leahy

3. (b) If veteran, name was no \*\*\*\*\*

3. (c) Social Security No. none \*\*\*\*\*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 3  
year 1948 hour 1 minute A. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Maurice R. Leahy

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

7. Birth date of deceased September 24 1870  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 18 1948 to Feb. 3 1948  
that I last saw her alive on Feb. 3 1948  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>4</u>	<u>29</u>	hr. min.

Immediate cause of death Carcinoma of rectum

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

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

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

10. Usual occupation Housewife

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

12. Name Charles Mahan

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

14. Maiden name Josephine Wheeler

15. Birthplace No Record  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Gertrude Shepard

(b) Address 1407 East 10th.

17. (a) Burial (b) Date thereof 2-4-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln, Nebraska

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

(b) Address 918-920 Brooklyn

19. (a) 2-4-48 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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

Major findings:  
-Of operations: \_\_\_\_\_

Of autopsy None

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)  
(e) Means of injury \_\_\_\_\_

23. Signature W. W. Hart (M. D. or other) W. W. Hart  
Address Med. Dir. Gen'l Hosp. Date signed 2-3-48

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

MOTHER FATHER

*Dr. Thomas*

**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 *Joe B. Yoder*  
Licensed Embalmer No. *4173*

P. O. Address *918 Brooklyn*

**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. *K.C. Mo.*