

FILED FEB 19 1949

STANDARD CERTIFICATE OF DEATH

State File No. 1312

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 106

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>2 days</u>		d. STREET ADDRESS (If rural, give location) <u>548 Main</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital #1</u>			

3. NAME OF DECEASED (Type or Print) <u>Lester</u>		a. (First) _____ b. (Middle) _____ c. (Last) <u>Leach</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1-8-49</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>March 3, 1896</u>		9. AGE (In years last birthday) <u>52</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>J.J. Greer Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Wayne County, Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					

13a. FATHER'S NAME <u>Robert F. Leach</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca Wolfinger</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Investigation</u>	ADDRESS <u>2332 Monitor</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>perforated duodenal ulcer with generalized peritonitis</u>		<u>2 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>541.1</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Jan. 6, 1949, to Jan. 8, 1949, that I last saw the deceased alive on Jan. 8, 1949, and that death occurred at 9:14 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Wm. W. Hart</u> (Degree or title)	23b. ADDRESS <u>Med. Dir. Gen'l Hsop #1 KC, MO.</u>	23c. DATE SIGNED <u>1-9-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>1-10-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New York Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Wayne County, Iowa</u>
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DATE REC'D BY LOCAL REG. <u>1-10-49</u>	REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>D. C. U. Weibel</u>	ADDRESS <u>2332 Monitor Place</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Blaine E. Weigand*

Licensed Embalmer No. *4075*

P. O. Address *K.C. 8, 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.