

FILED NOV 5 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

33993

4807

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

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) OR TOWN <u>KANSAS CITY</u>	c. LENGTH OF STAY (in this place) <u>30 YRS</u>	c. CITY OR TOWN <u>KANSAS CITY</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2715 BALES AVENUE</u>		STREET ADDRESS (If rural, give location) <u>2715 BALES AVENUE 3368</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>FLORA</u>	b. (Middle) <u>ANN</u>	c. (Last) <u>LEAVITT</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 14 1954</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>AUG. 21, 1861</u>	9. AGE (In years last birthday) <u>93</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>FREMONT, OHIO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>UNKNOWN BOWLUS</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>ALBERT T. LEAVITT</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. LILLIAN ALLEN, 2715 BALES AVE., K.C., MO.</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>Ventricular fibrillation</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>a.s. Cardiovascular dis.</u> DUE TO (c) <u>Age & Carcinoma - 7.2 yrs</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Metastatic Carcinoma -</u>		4221	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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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?
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22. I hereby certify that I attended the deceased from 6-13, 1954, to 10-14, 1954, that I last saw the deceased alive on 10-13, 1954, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert B. Hodgson</u> (Degree or title)	23b. ADDRESS <u>105829 Woodson Mission</u>	23c. DATE SIGNED <u>10-14-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>OCT-16-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MT. WASHINGTON CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>10-16-54</u>	REGISTRAR'S SIGNATURE <u>Neve Marshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>D.N. Proctor Sons 1331 BRUSH CREEK KANSAS CITY, MO.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

7th 8060

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.....
Signature of Student Embalmer

Signed... *Chester K. Brown*

Licensed Embalmer No... 79

P. O. Address... *K.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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.