

Health,
& Welfare
Public
Service

S. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Leo A. O'Brien

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40515
STATE FILE NUMBER
5098

FILED NOV 20 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Wyandotte | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Queen of the World | | Length of stay in 1b 1 day | d. STREET ADDRESS (If outside, give location) 433 Richmond | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last LEVI MOTON | | | 4. DATE OF DEATH Month Day Year 10-28-57 | | |
| 5. SEX Male | 6. COLOR OR RACE Col. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 8-25-1904 | 9. AGE (In years last birthday) 53 | IF UNDER 1 YEAR Months Days 53 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Mo. Pac. R.R. | 11. BIRTHPLACE (City and state or country) Miss. | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13a. FATHER'S NAME Wash Moton | | 13b. MOTHER'S MAIDEN NAME Rose ? | | 14. NAME OF HUSBAND OR WIFE Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 719-12-4633 | | 17. INFORMANT Address Roberta Wagner 433 Richmond | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coronary arterio sclerosis | | | | | 2 1/2 Mo |
| DUE TO (c) Several arterio sclerosis | | | | | 2 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) He had asthma for 2 yrs | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from 1949 to Oct 28-1957 and last saw him alive on October 27-57 Death occurred at 11:30 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Dr Leo A. O'Brien M.D. | | | 22b. ADDRESS 706 E 12 K.C. Mo. | | 22c. DATE SIGNED 10-30-57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 11-2-57 | 23c. NAME OF CEMETERY OR CREMATORY Maple Hill Cem. | | 23d. LOCATION (City, town, or county) (State) Kansas City, Kansas |
| 24. FUNERAL DIRECTOR ADDRESS Nathan W. Thatcher K.C.K. | | | 25. DATE RECD. BY LOCAL REG. 11-1-57 | 26. REGISTRAR'S SIGNATURE Neva Marshall | |

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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 _____
Signature of Student Embalmer

Signed Califf J Woods

Licensed Embalmer No. 3106

P. O. Address 1520 N. Main

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.