

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 21 1959

**59-029155**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3851 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u>37 yrs</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3423 Charlotte</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Menorah Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3423 Charlotte</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <u>MARY</u> Middle <u>AGNES</u> Last <u>LECKENBY</u>			<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>6</u> Year <u>1959</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Dec 12, 1891</u>	<b>9. AGE (last birthday)</b> <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>New York, N. Y.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>
<b>13a. FATHER'S NAME</b> <u>John Whalen</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Susan Unknown</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Clarence Leckenby</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>487-07-8934</u>		<b>17. INFORMANT</b> Address <u>Route 6</u> <u>John Francis Leckenby, Florence, Ala.</u>		

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bronchopneumonia, bilateral</u> DUE TO (b) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>Chronic myelogenous leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>				
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>Aug 6, 1959</u> <b>to</b> <u>August 6-59</u> <b>and last saw her/him alive on</b> <u>8-6-59</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					

<b>22a. SIGNATURE</b> (Degree or title) <u>David Waxman, M.D.</u>		<b>22b. ADDRESS</b> <u>4845 Forest</u>		<b>22c. DATE SIGNED</b> <u>8-8-59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial &amp; Removal 8-8-59</u>	<b>23b. DATE</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Michaels Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Florence, Alabama</u>	
<b>24. FUNERAL DIRECTOR</b> <u>MELLODY-MOCHESLEY-EYLAR</u> <u>WOODLAND &amp; LINWOOD</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>8-9-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Reva Marshall</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

David Waxman

La U. A. May 20  
Street 117 Bldg  
Vi 2-3925

1:30 PM 2:30 PM

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed George Jackson

Licensed Embalmer No. 5059

P. O. Address K. O., Ill

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.