N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEC'D SEP 13 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

28079
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kaw
(c) City Kansas City
Registration District No. 399
Primary Registration District No. 1002
Registered No. 3390
(d) Street No. St. Joseph Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 15 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Leonard Simpson 512
(a) Residence, No. 2915 Linwood Blvd. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mrs. Alice Simpson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): July 19, 1894

7. AGE: YEARS 44 | MONTHS 1 | DAYS 7 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Manager
9. Industry or business in which work was done, as saw mill, bank, etc.: Kansas City Club
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

FATHER
13. NAME: Don't Know
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

MOTHER
15. MAIDEN NAME: Don't Know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

17. INFORMANT (ADDRESS): Mrs. Alice Simpson, 2915 Linwood Blvd.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Cincinnatti, Ohio DATE 8-27-38, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Freeman Mortuary, Kansas City, Mo.

20. FILED Aug 27, 1938 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-26-38, 19

22. I HEREBY CERTIFY, That I attended deceased from 8-21-38, 19, to 8-26-38, 19
I last saw him alive on 8-26-38, 19 Death is said to have occurred on the date stated above, at 5 P.m.
The principal cause of death and related causes of importance were as follows:

Post Operative Paralytic Ileus — Acute Hepatitis + Nephritis. 122B2

Date of onset

Other contributory causes of importance:
Incisional Hernia

Name of operation Hemorrhaphy Date of 8-22-38
What test confirmed diagnosis? Autopsy Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? 4
If so, specify
(Signed) Russell W. Kerr, M. D.
(Address) Kansas City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

NOV 1 1 1942

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.