

No. 2  
1-4-41  
-17-39  
X26390

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

24087

State File No. ....

FILED AUG 16 1941 19

Registration District No. .... Primary Registration District No. 1002

Registrar's No. 2626

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether)

In this community 12 Yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 1012 Cherry St. (If rural, give location)

(e) Citizen of foreign country? (Yes or No) No  
If yes name country

3. (a) PRINT FULL NAME LEON W. WIER

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9th  
year 1941 hour 10:00 P.M. minute M.

4. Sex M - 0 5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mabel Carter

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased 4 (Month) 15 (Day) 1894 (Year)

21. I hereby certify that I attended the deceased from 7-8-41 1941 to 7-9-41 1941;

that I last saw him in live on 7-9-41 1941 and that death occurred on the date and hour stated above.

8. AGE: Years 47 Months 2 Days 25 If less than one day hr. min.

Immediate cause of death Cerebral hemorrhage

Duration

9. Birthplace Howard Co Mo (City, town, or county) (State or foreign country)

Due to gza

Due to gza

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Retired

Major findings: Of operations

Of autopsy see above

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business

12. Name William W. Wier

13. Birthplace Va (City, town, or county) (State or foreign country)

14. Maiden name Sarah Markland

15. Birthplace Howard Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mable Wier

(b) Address 1001 Penn

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 7-12-41 (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address K.C.

While at work? (Specify type of place)

(c) Means of injury

19. (a) 7-12-41 (Date received local registrar)

(b) M. M. Crow (Registrar's signature)

23. Signature Dwain R. Thow (M. D. or other)

Address Ed. Dir. K.C. Gen. Hospital Date signed

361 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE 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.....

....., 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 comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**