

No. 2
1-4-41
1-17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30703

FILED OCT 15 1941

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3460

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
General Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 23 years
(Specify whether 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. 1211 Highland
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME LEON WOODARD

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 16 1918
(Month) (Day) (Year)

8. AGE: Years <u>23</u>	Months <u>2</u>	Days <u>27</u>	If less than one day hr. _____ min. _____
-------------------------	-----------------	----------------	--

9. Birthplace Kansas City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Taxi driver

11. Industry or business _____

12. Name Deceased - _____

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

14. Maiden name Deceased

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 9-17-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Maple Hill

18. (a) Signature of funeral director W. Jones

(b) Address 440 State Ave.

19. (a) 9/16/1941 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12
year 1941 hour 8 minute 53 p. M.

21. I hereby certify that I attended the deceased from September 3, 1941 to September 12, 1941
that I last saw him alive on September 12, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Ruptured spleen
Cause, probably abdominal
Hodgkin's

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. Jones (M. D. or other) _____

Address Gen Hosp #2 Date signed 9-15-41

WRITE FLATLY - NEVER USE BLACK INK - MAKE A PERMANENT RECORD

MOYER FATHER

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

E. Sterling Ballew

Licensed Embalmer No. *3178*

P. O. Address *1811 E. 12th St. H.K.*

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.