

No. 2
5-43
X 36671

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF CENSUS
FILED MAR 12 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. **4963**

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 16

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Excelsior Springs, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Excelsior Springs Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 mo. (Specify whether years, months or days)
In this community several years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clay 24
(c) City or town Excelsior Springs
(If outside city or town limits, write "RURAL")
(d) Street No. 409 E. Broadway (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Way Leininger
3. (b) If veteran, name war **(c) Social Security No.** No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 27th
year 1946 hour 11 minute 20 P. M.
21. I hereby certify that I attended the deceased from my
19 1945 to Jan 27 1946
that I last saw her alive on Jan 27 1946
and that death occurred on the date and hour stated above.

4. Race White **5. Color** White **6. (a) Single, widowed, married, divorced** Widowed
6. (b) Name of husband or wife John Leininger **6. (c) Age of husband or wife if alive** 5-1-1872 years
7. Birth date of deceased (Month) (Day) (Year)

Immediate cause of death: Congestive heart failure -
Duration since May 4th
Due to chronic bronchitis to my knowledge
Due to arteriosclerosis
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy 0 97
PHYSICIAN
Underline the cause to which death should be charged statistically.

8. AGE: Years 73 Months 8 Days 26 If less than one day hr. min.
9. Birthplace New York New York
(City, town, or county) (State or foreign country)
10. Usual occupation none

MOTHER **FATHER**
11. Industry or business
12. Name Edward McPherson
13. Birthplace Wisconsin
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Anna Leininger
(b) Address 720 E. Grand Blvd., N. C. Mo
17. (a) Burial, cremation, or removal Excelsior **(b) Date thereof** 1-27-46
(Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn Cemetery, N. C. Kansas
18. (a) Signature of funeral director: Richard D. Ray
(b) Address Kansas City, Kansas
19. (a) 2-6-46 **(b) Caroline Hutchings**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(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 D
23. Signature S. R. M. Crocker (M. D. or other) MO
Address Excelsior Springs, Mo Date signed 1/28/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

2-8-46

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

George M. Malley

Licensed Embalmer No. 27980

P. O. Address Kansas City, Kansas

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.