

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

39249

State File No. _____
 Registrar's No. **5447**

FILED DEC 2 - 1953

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. 5447	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson			
b. CITY OR TOWN Kansas City		c. LENGTH OF STAY (In this place) 30 yrs		c. CITY OR TOWN Kansas City		d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1				e. STREET ADDRESS (If rural, give location) 3816 E. 25 3368			
3. NAME OF DECEASED (Type or Print) Leonard		a. (First)		b. (Middle) Riddle		4. DATE OF DEATH (Month) (Day) (Year) 11 17 1953	
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 1		8. DATE OF BIRTH 14 Jan 1887	
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY City		11. BIRTHPLACE (City and State or Foreign Country) Preston, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Joe Riddle		13b. MOTHER'S MAIDEN NAME Dorothy Richardson		14. NAME OF HUSBAND OR WIFE Mail M. E. Riddle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME M. E. Riddle ADDRESS 3816 E. 25. K.C. Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia ANTECEDENT CAUSES Chronic urinary infection Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Peripheral urinary obstruction <i>Benign prostatic hypertrophy</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION _____					INTERVAL BETWEEN ONSET AND DEATH 6/10 X
19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>Nov. 10</u> , 19 <u>53</u> , to <u>Nov. 17</u> , 19 <u>53</u> , that I last saw the deceased <input checked="" type="checkbox"/> alive on <u>Nov. 17</u> , 1953, and that death occurred at <u>12:25A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE B. I. Burns (Degree or title) M.D.				23b. ADDRESS 24th & Cherry		23c. DATE SIGNED 11-17-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Bu-121		24b. DATE Nov 19 - 53		24c. NAME OF CEMETERY OR CREMATORY Floral Hills		24d. LOCATION (City, town, or county) (State) Kansas City, MO	
DATE REC'D BY LOCAL REG. 11-17-53		REGISTRAR'S SIGNATURE Sheraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Floral Hills Memorial Chapels K.C. Mo			

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

Dr. Wm

REC'D JAN 1953

DEC 31 1953

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Wm Blandford*

Licensed Embalmer No. *401*

P. O. Address *K C M*

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.