THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

24846

STATE FILE NUMBER 3342

FILED AUG 12 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

**1. PLACE OF DEATH**

a. COUNTY: Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City — Inside Limits: Yes ☒ No ☐

c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION: 2836 Benton — Length of stay in this place: 63yrs

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)

a. STATE: Missouri b. COUNTY: Jackson

c. CITY OR TOWN: Kansas City — Inside Limits: Yes ☒ No ☐

STREET ADDRESS (If outside, give location): 2813 Myrtle — Reside on Farm: Yes ☒ No ☐

**3. NAME OF DECEASED** (Type or print): First: Leon Middle: Last: Steele

**4. DATE OF DEATH** Month: 7 Day: 14 Year: 57

**5. SEX:** male

**6. COLOR OR RACE:** Negro

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH:** April 29, 1894

**9. AGE** (In years last birthday): 63 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): retired

**10b. KIND OF BUSINESS OR INDUSTRY:** fireman

**11. BIRTHPLACE** (City and state or country): Kansas City, Mo.

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Courtney Steele

**14. MOTHER'S MAIDEN NAME:** Mattie McCabe

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, No or unknown): yes (If yes, give war or dates of service): WWI

**16. SOCIAL SECURITY NO.:** 497-40-1414

**17. INFORMANT:** Mattie White Address: 2813 Myrtle

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 monhs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Septicemia

DUE TO (c) Prostatic Abscess (m. m. o.) — 611 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT** ☐ **SUICIDE** ☐ **HOMICIDE** ☐

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year

**20d. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐

**20e. PLACE OF INJURY** (e. g., in or about home, farm, factory, street, office bldg., etc.)

**20f. CITY, TOWN, OR LOCATION** COUNTY STATE

**21.** I attended the deceased from ~~July~~ March 4, 57 to July 14, 57 and last saw her/him alive on July 14, 57

Death occurred at 10:20 A.m. on the date stated above; and to the best of my knowledge, from the causes stated.

**22a. SIGNATURE** (Degree or title): P. C. Turner M. D.

**22b. ADDRESS:** 1433 E. 19th St.

**22c. DATE SIGNED:** 7-15-57

**23a. BURIAL, CREMATION, REMOVAL** (Specify): burial

**23b. DATE:** 7-17-57

**23c. NAME OF CEMETERY OR CREMATORY:** Highland

**23d. LOCATION** (City, town, or county) (State): Kansas City Mo.

**24. FUNERAL DIRECTOR** ADDRESS: Watkins Bros. Fa Km. 18th & Benton

**25. DATE RECD. BY LOCAL REG.:** 7-17-57

**26. REGISTRAR'S SIGNATURE:** Nera Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

9th 1-6533

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Bruce R. Watkins

Licensed Embalmer No. 45

P. O. Address 18th Bu

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.