

REC'D AUG 7 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

24434

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Kaw Primary Registration District No. 1002 Registered No. 2647
(c) City Kansas City (d) Street No. Memorial Hosp St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

1592 Sarah Dubinsky
(a) Residence, No. 5320 Rockhill Rd. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF SIMON DUBINSKY
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 76

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. At Home
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia 1

FATHER 13. NAME Not known ?
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known 9

MOTHER 15. MAIDEN NAME Not known
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT (ADDRESS) Ed. Dunwood
K.C. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE MT. CARMEL DATE July 2, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J.P. LOUIS FUNERAL HOME
CITY

20. FILED July 2 1939 M. B. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-1-1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1939 to July 1, 1939
I last saw him alive on July 1, 1939 Death is said to have occurred on the date stated above, at 4:30 P.M.

The principal cause of death and related causes of importance were as follows:

Ill oligemancy of p. anemias
46

Date of onset

2 mos

Other contributory causes of importance:

Heart decompensation with
acute renal abscess
Name of operation Cholecystotomy Date of 6 weeks ago
What test confirmed diagnosis? Exam Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) William G. Quabron, M. D.
(Address) 420 Prof.

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, above space should be left blank.