

REC'D SEP 6 1939

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

28208
Do not use this space.

1. PLACE OF DEATH
(a) County JACKSON Registration District No. 395
(b) Township HAW Primary Registration District No. 1002 Registered No. 3210
(c) City KANSAS CITY (d) Street No. 4821 STATE LINE 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ALTA BORDMAN
(a) Residence, No. 4821 STATE LINE 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 FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF JOSEPH BORDMAN
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 25 1887
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 51 7 18
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House WIFE
9. Industry or business in which work was done, as saw mill, bank, etc.
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) ST. PETERSBERG.
13. NAME AARON KAZANSKY
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) VILNA
15. MAIDEN NAME FANNIE NEW
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) VILNA.
17. INFORMANT JOSEPH BORDMAN (ADDRESS) 4821 STATE LINE
18. BURIAL, CREMATION, OR REMOVAL PLACE SHARE SNOLOM DATE AUG. 14 1939
ST. JOSEPH MD
19. FUNERAL DIRECTOR (NAME) (ADDRESS) F. P. LOUIS FUNERAL HOME
5 CITY
20. FILED 914 39 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) AUG. 13 1939
22. I HEREBY CERTIFY, That I attended deceased from June 28 to Aug. 13 1939
I last saw her alive on Aug 12 1939 Death is said to have occurred on the date stated above, at 11 P. M.
The principal cause of death and related causes of importance were:
Carcinoma of lungs metastatic from breast.
Other contributory causes of importance:
Name of operation none Date of
What test confirmed diagnosis? none Was there an autopsy?
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury
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 M. Keith M. D.
(Address) 612 Professional Bldg. Kansas City Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DR. NORTH
SA Joseph Hoop

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

28208
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township..... Primary Registration District No. 1002
(c) City K.C. (d) Street No..... Registered No. 3210
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Alta Wardman 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
51 7 10

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.
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) Petersburg, Fla.

FATHER 13. NAME Caron Kazarski

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Vilnius, Lithuania

MOTHER 15. MAIDEN NAME Jennie New

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Delia

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 8/14/39 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-13-39

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...

I last saw h... alive on..., 19... Death is said to have occurred on the date stated above, at... m.

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

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

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?

If so, specify (Signed) Wm M Keith, M. D.

(Address) K.C. Mo.

N. B.—Every item of information should be carefully applied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 3210

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4821 State Line
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days)

8. (a) PRINT FULL NAME Alta Boardman

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex ♀ 5. Color or race Wh. 6. (a) Single, widowed, married, divorced, Married

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

7. Birth date of deceased Dec. 20th 1887
(Month) (Day) (Year)

8. AGE: Years 51 Months 3 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace St Petersburg Fla
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Aaron Kazansky

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

14. Maiden name Janus

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

16. (a) Informant's own signature A. Boardman

(b) Address 4821 State Line

17. (a) Burial (b) Date thereof 9/14/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph Mo

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

(b) Address St. Mo

19. (a) 9/14/39 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 4821 State Line
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 13th
year 1939 hour 11 minute 7 M.

21. I hereby certify that I attended the deceased from 6-19-28, 19____, to 8-12, 1939;
that I last saw her alive on 8-12-, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Lung metastatic
Due to Cancer of Bronchopneumonia
Due to _____

Duration

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

Major findings: 50
Of operations _____

Of autopsy _____

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 Wm. M. Korth (M. D. or other) _____

Address Profess Bldg Date signed _____

USE WRITING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

(Copy)

(52)-28208

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.