

SEP 6 1939

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

28211
Do not use this space.

3213

1. PLACE OF DEATH

(a) County JACKSON Registration District No. 395
(b) Township HAW Primary Registration District No. 100
(c) City KANSAS CITY (d) Street No. 3515 Woodland 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 MAX DANIELS

(a) Residence, No. 3515 WOODLAND 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 MALE 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 Rose DANIELS

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JUNE 5, 1898

7. AGE YEARS 41 MONTHS 2 DAYS 8 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. SHOE MAKER
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) POLAND

FATHER 13. NAME HYMAN JACOB DANIELS

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) POLAND

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT Rose DANIELS (ADDRESS) 3515 WOODLAND

18. BURIAL, CREMATION, OR REMOVAL PLACE SHEFFIELD DATE AUG. 14, 1939

19. FUNERAL DIRECTOR (NAME) J. P. Lewis FUNERAL HOME (ADDRESS) 914 N. W. Grove

20. FILED 1939 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 White Coronary to White Coronary, 19..... Death is said to have occurred on the date stated above, at 12:30 P.M.
The principal cause of death and related causes of importance were as follows:

Coronary sclerosis
Chronic diffuse myocardial fibrosis
Acute pulmonary edema
Congestion
Date of onset 9/20

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 of injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) Walter H. Richter, M. D.
(Address) H. P. 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.

MAR 23 1945

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.