DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31623

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3721

1. PLACE OF DEATH: OCT 18 1939

(a) County Jackson

(b) City or town Kaw
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Luke's Hospital, K.C.Mo.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Missouri.
(If outside city or town limits, write "RURAL")

(d) Street No. 4125 Monroe Avenue, K.C.Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Arnold M. Zuck

3. (b) If veteran, name war None

3. (c) Social Security No. 486-10-5475

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Gladys M. Zuck

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

7. Birth date of deceased Iowa April 29, 1990
(Month) (Day) (Year)

8. AGE: Years 38 | Months | Days | If less than one day _____ hr. _____ min.

9. Birthplace State of Iowa.
(City, town, or county) (State or foreign country)

10. Usual occupation Book-keeper Produce Excg. Bank

11. Industry or business -------

FATHER
12. Name J. Arthur Zuck
13. Birthplace Iowa
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Maude Noble
15. Birthplace Iowa.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Gladys M. Zuck,
(b) Address 4125 Monroe, K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24 39
(Month) (Day) (Year)
(c) Place: burial or cremation Ships to Baker Kansas

18. (a) Signature of funeral director Mrs. C.L. Forster
(b) Address 918 Brooklyn Avenue, K.C.Mo.

19. (a) 9/24/39 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 22nd, 1939
year 1939 hour _____ minute _____ P.M.

21. I hereby certify that I attended the deceased from Aug 20, 1939 to Sept 22, 1939
that I last saw him alive on Sept 22, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Involving Left Descending Branch — Duration 4 hrs

Due to 94 B

Due to

Other conditions Pulmonary Infarct (Rt) 3 hrs
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Above findings

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address [illegible] Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

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 C. N. Nice

Licensed Embalmer No. 2570 Mo

P. O. Address 918 Brooklyn KC

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit 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

31623
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township — Primary Registration District No. 1002 — Registered No. 3721
(c) City K. C. — (d) Street No. ..... 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 Arnold M. Zuck.
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 29 1890

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	38			

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.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ....., 19..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 9/24 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 22, 1939

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) D. L. Slaffer, M. D.
(Address) 1414 Rockfield Bldg

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.