

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

31676
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Near Primary Registration District No. 1902
 (c) City Wass City (d) Street No. Monah Hospital Registered No. 3774
 (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 Emmie Raifetz
 (a) Residence, No. 3001 Forest 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 Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wilhelm Raifetz
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 20 1903
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
26 2 9
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 29 1939
 22. I HEREBY CERTIFY, that I attended deceased from Sept 14, 1939, to Sept 29, 1939
 I last saw her alive on Sept 29, 1939. Death is said to have occurred on the date stated above, at 9:30 A.M.
 The principal cause of death and related causes of importance were as follows:
Acute atrophy of liver
 Date of onset 125B3
 Other contributory causes of importance:
 Name of operation _____ Date of _____
 What test confirmed diagnosis? Autopsy Was there an autopsy? yes
 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) Edw. J. Bely M. D.
 (Address) 728 - Abryl, Bely

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Romania
 FATHER 13. NAME Elias Goldstern
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Romania
 MOTHER 15. MAIDEN NAME Sarah F. Smaller
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Romania
 17. INFORMANT (ADDRESS) Wm S. G. Bart
4319 Stephen
 18. BURIAL, CREMATION, OR REMOVAL, Interment
 PLACE Missouri DATE Sept 29 1939
 19. FUNERAL DIRECTOR (NAME) Carroll Davidson
 (ADDRESS) 3024 Forest
 20. FILED 9/29 1939 M. M. Crowe
 Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

1 X10605

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 *yes*

....., Registered Apprentice No.

working under my personal supervision.

Signed

E. P. Casey

Licensed Embalmer No. *1972*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31676
Registrar's No. 3774

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town R.C.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Annie Raiferts

3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one year
26 7 9 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 9/28/39 (b) Mr. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH: Month Sept. 29 - 29 -
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19....., and that death occurred on the date and hour stated above.

Immediate cause of death acute atrophy of liver
Due to..... } Exact cause not determined. Pathological report has not been returned - as yet
Due to..... }
Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....
Of autopsy yes 12418

Duration
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..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

