

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34878
 Do not use this space.

NOV 14 1939

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399

(b) Township Flour Primary Registration District No. 1002

(c) City Kansas City Street No. Memorial Hospital Registered No. 3853 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 Robert Ray Stein 350

(a) Residence, No. 7141 Washington 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 Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) None single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 13 1939

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

X	X	12	
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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) Kansas City Mo.

13. NAME Louis Stein

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canton Ohio

15. MAIDEN NAME Ida Kutner

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York New York

17. INFORMANT (ADDRESS) Louis Stein 12.07 mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Shelfield Cem 9-25-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. E. J. M.

20. FILED 10-5 39 m. m. Crove Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 25 19 39

22. I HEREBY CERTIFY, That I attended deceased from Sept 13 19 39 to Sept 25 19 39

I last saw h. 27 alive on Sept 25 19 39 Death is said to have occurred on the date stated above, at 7 a. m.

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

Prematurity

Date of onset Birth

Other contributory causes of importance: Cerebral Hemorrhage generalized

Name of operation clinical Date of 16 0 0

What test confirmed diagnosis? autopsy 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? no

If so, specify _____

(Signed) Delroy F. Paschke

(Address) 628 Puy Bldg

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.

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25 37 - 1/14

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.