

DEC 21 1939
Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Jackson City
(c) Name of hospital or institution St Luke Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 week
In this community 10 years
years, months or days (Specify whether)

8. (a) PRINT FULL NAME Marcella Fay Rodin
8. (b) If veteran, name war no
8. (c) Social Security No. no

4. Sex Fe **5. Color or race** wh
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased Dec 14, 1918
(Month) (Day) (Year)
8. AGE: Years 20 Months 11 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____
12. Name Carl H. Rodin
13. Birthplace Brooklyn, Russia
(City, town, or county) (State or foreign country)
14. Maiden name Rose Goldberger
15. Birthplace New York, New York
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Carl H. Rodin
(b) Address 409 E. Gregory
17. (a) Burial _____ **(b) Date thereof** 11-22-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Rose Hill
18. (a) Signature of funeral director Carroll Davidson
(b) Address 3024 Prospect
19. (a) Nov 21 1939 **(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 Jackson City
(If outside city or town limits, write "RURAL")
(d) Street No. 409 E. Gregory
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 19
year 1939 hour 11 minute _____ a. M.
21. I hereby certify that I attended the deceased from Sept 18, 1939, to Nov 19, 1939;
that I last saw her alive on Nov 19, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death acute pyelo nephritis
Thrombosis Left Aorta Vein
Due to Infection
Due to _____

Other conditions (Includes pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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 Ravitchwanis (M. D. or other) _____
Address 820 prof 1283 Date signed 11-21-39

Duration _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING 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.

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

E. P. Casey

Licensed Embalmer No.

1972

P. O. Address

3024 Proost

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. 38682-7

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

Registrar's No. 4447-

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K.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 _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Marcella Rodin

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 1-

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 day
20 11 5 _____ 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) _____ (b) _____
(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 Nov. 19 day 29 -
year _____ hour _____ minute _____ M.

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

Immediate cause of death
Acute pyelonephritis
Thrombosis of renal vein
Due to Chronic kidney infection
no pregnancy
Other conditions: Due to infection
(Include pregnancy within 3 months of death)

Major findings: no
Of operations _____
Of autopsy no. unable to obtain

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 Rauscher (M. D. or _____)
Address 820 prop Bldg Date signed _____

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

ROWENA MOORE

