

S. No. 2
-11-10-39
-5-17-39
-1 X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **9593**
1027
Registrar's No.

Registration District No. **399** Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Menorah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Weeks**
(Specify whether years, months or days)
In this community **Ab. 550 Yrs.**

3. (a) PRINT FULL NAME **Fannie Alster** **423**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Jacob Alster** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: Years **78** Months **-** Days **-** If less than one day _____ hr. _____ min.

9. Birthplace **Unknown** **Austria** 7
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business
MOTHER FATHER { 12. Name **Unknown** 7
13. Birthplace **Unknown** **Austria**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** **Austria**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ruth Alster**
(b) Address **Leavenworth, Kansas**

17. (a) **Removal** (b) Date thereof **3-6-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Leavenworth, Kansas**

18. (a) Signature of funeral director **J. P. Louis Funeral Home**
(b) Address **3400 Woodland, Kansas City, Mo.**

19. (a) **Mch 6, 1940** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County _____
(c) City or town **Leavenworth**
(If outside city or town limits write "RURAL")
(d) Street No. **509 Pottawatomie**
(If rural, give location)
(e) If foreign born, how long in U. S. A? **About 50 Years** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **5**
year **1940** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from **Feb 21**
1940, to **March 5**, 1940.
that I last saw him alive on **3/5/40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death:
(1) Ulcerative Colitis
(2) Negative Discharge
(3) Scurvy
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____
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 **P. C. Criss** (M. D. or other) **M.D.**
Address **625 Puffer Bldg** Date signed **3/5/40**

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.....

But Logan

Licensed Embalmer No. 3879

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.