

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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 5 weeks
(Specify whether
In this community 19 years
years, months or days)

3. (a) PRINT FULL NAME Aaron Stein 350
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Esther Stein 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased March 24 1884
(Month) (Day) (Year)

8. AGE: Years 55 Months 11 Days 23 If less than one day
hr. _____ min. _____

9. Birthplace Russia 7
(City, town, or county) (State or foreign country)
10. Usual occupation Retired

11. Industry or business _____
12. Name Leon Stein 7
13. Birthplace Russia (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant L Albert Stein
(b) Address 4344 Montgal, K. C. Mo.
17. (a) Burial (b) Date thereof 3-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sheffield

18. (a) Signature of funeral director J. P. Louis Funeral Home
(b) Address 3400 Woodland, K. C. Mo.
19. (a) 3-18-40 (b) M. M. Crave
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limit, write "RURAL")
(d) Street No. 4032 Michigan
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 19 Years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 18
year 1940 hour 12 minute 30 A. M.
21. I hereby certify that I attended the deceased from 3/10
1940, to 3/11 1940
that I last saw him alive on 3/11 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Hadzhin disease 2 yrs.
Duration
Due to " " 72 yrs
Due to " " "
Other conditions Phlebitis left leg
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy None
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 Paul Thomas M.D. (M. D. or other)
Address 2008 Bryn Mawr Rd Date signed 3/18/40

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

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.....

..... *Myself* Registered Apprentice No.
working under my personal supervision.

Signed *Bert Legan*

Licensed Embalmer No. *3979*

P. O. Address *F.C. Mrs.*

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.