

MAY 15 1940

Registration District No. 399

Primary Registration District No. 1002

State File No.

Registrar's No. 1518

1. PLACE OF DEATH:

(a) County Jackson Mo
(b) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Menarrah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution One Day
(Specify whether
In this community _____
years, months or days)

8. (a) PRINT FULL NAME Winetroub, Mr. Joseph
8. (b) If veteran, name war No
8. (c) Social Security No. No

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Elsie Winetroub
6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Dec. 20, 1882
(Month) (Day) (Year)

8. AGE: Years 57 Months 4 Days 8
If less than one day hr. min.

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

10. Usual occupation Merchant

11. Industry or business Dry goods

12. Name Wm Winetroub

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

14. Maiden name Hannah Cohen

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

16. (a) Informant Mrs Joe Winetroub

(b) Address Leis Summit Mo.

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof _____
(Month) (Day) (Year)

(c) Place: burial or cremation St. Louis Mo

18. (a) Signature of funeral director Fields Funeral Home

(b) Address Leis Summit, Mo.

19. (a) April 29, 1940 (b) M. N. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Leis Summit Mo
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29
year 1940 hour _____ minute 30 P.M.

21. I hereby certify that I attended the deceased from 4/22/40
_____ 19____ to 4/29 1940

that I last saw him alive on 4/29 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coronary Thrombosis 36 hrs.
Myocarditis 5 years.

Due to Cardiac failure acute

Due to 94 B

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy Myocarditis
Films of Cardiac muscle

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no.
(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 1

23. Signature W. W. Crowe (M. D. or other) _____
Address 625 Oakes St Date signed 4/29/40

Duration
36 hrs.
5 years.
acute
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed P. C. Fields

Licensed Embalmer No. 2759

P. O. Address Leis Summit Ma

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.