DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JUL 17 1917

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21535

Registration District No. 201 Primary Registration District No. 5280 Registrar's No. 48

1. PLACE OF DEATH:

(a) County Unknown

(b) City or town Unknown
(If outside city or town limits, write "RURAL" and name of township)

(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 3900 Flora
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Archie Solsky

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

4. Sex Male 5. Color or race Jewish 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive None years

7. Birth date of deceased Sept (Month) 27 (Day) 1917 (Year)

8. AGE: Years 22 Months 8 Days ? If less than one day ____ hr. ____ min.

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

10. Usual occupation At home

11. Industry or business " "

FATHER
12. Name P Solsky
13. Birthplace (City, town, or county) Russia (State or foreign country)

MOTHER
14. Maiden name Katy Lomansky
15. Birthplace Russia (City, town, or county) (State or foreign country)

16. (a) Informant's own signature W L Wysong
(b) Address Liberty, Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Kansas City Mo

18. (a) Signature of funeral director Hussel-Carden
(b) Address Liberty, Mo

19. (a) June 12-40 (Date received local registrar) (b) Helen Early (Registrar's signature) A.R.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ✓ day ____
year ____ hour ____ minute ____ M.

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

Immediate cause of death ____ Duration

Due to Suicide by Drowning in Mo River

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) Suicide
(b) Date of occurrence Unknown
(c) Where did injury occur? Mo River (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 Mrs W L Wysong Coroner (M. D. or other)
Address Liberty Clay Co Missouri Date signed ____

(Licensed Embalmer's Statement on Reverse Side)

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 s[illegible]
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importa[illegible]

1 X19511

RECEIVED
District Health Officer No. 8,
District File Number 7-15-40
Date Filed

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21535

Registration District No. 201 Primary Registration District No. 5280 Registrar's No. 48

1. PLACE OF DEATH:

(a) County Clay

(b) ~~City or town~~ Liberty T.P.
(If outside city or town limits, write "RURAL" and name of township)

(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 (S[illegible]
In this community
years, months or days)

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.

3. (a) PRINT FULL NAME Archie Sulsky

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race Jewish

6. (a) Single, widowed, married, divorced D.

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 22 Months 8 Days 7 If less than one day hr. min

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) June 2, 1940 (b) W. H. Shafer
(Date received local registrar) (Registrar's signature)
by H. Early ass't Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

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

Immediate cause of death

Duration

SUPPLEMENTARY

Boy disappeared about 25th of May. Found in river June 1st.

Paste on

SICIAN

derline ause to h death ld be ged sta- ally.

Urine

(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 Mrs W. L. [illegible] (M. D. or other) Cor

Address Liberty Mo Date signed