No. 2
4-13-40
5-17-39
I X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
REC SEP 5 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27498

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3131

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 Hosp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 4420 Paseo (If rural, give location)

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

3. (a) PRINT FULL NAME Sandra Naster 23b

3. (b) If veteran, name war No

3. (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 Aug 2, 1935 (Month) (Day) (Year)

8. AGE: Years 5 Months -- Days 3 If less than one day hr. min.

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

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Jack Naster
13. Birthplace Kansas City, Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Etta Hansberg
15. Birthplace Chicago Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Jack Naster

(b) Address 4420 Paseo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Carmel

18. (a) Signature of funeral director J. P. Louis Fun. Home

(b) Address City

19. (a) Aug. 5, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5th day August year 1940 hour 5 30 minute — M.

21. I hereby certify that I attended the deceased from 8/4/40, 19..., to 8/5/40, 19..., that I last saw her alive on 8/5, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death acute perforated gangrenous appendix

Due to overwhelming sepsis

Due to with early peritonitis

Other conditions (Include pregnancy within 3 months of death) 121

Major findings: Of operations gangrenous appendix

Of autopsy (only abdominal)

Duration

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) 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) MD

Address 1024 Prof Bldg Date signed 8/5/40

(Licensed Embalmer's Statement on Reverse Side)

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.....G. L. Lewis.....

Licensed Embalmer No.....3110.....

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, fact should be so stated above.