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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

27566
3199

SEP 5 1940
Registration District No. 399

Primary Registration District No. 1002

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: 620 Virginia 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community Unknown
years, months or days)

3. (a) PRINT FULL NAME Izzie Max Silver 416

3. (b) If veteran, name war X 3. (c) Social Security No. none

4. Sex M 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rose Silver 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 72 Months X Days X If less than one day X
hr. _____ min.

9. Birthplace Poland 7
(City, town, or county) (State or foreign country)

10. Usual occupation Junk Dealer

11. Industry or business _____

MOTHER FATHER { 12. Name Abraham

13. Birthplace Poland 7
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace Poland 7
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Rose Silver
(b) Address 620 Virginia

17. (a) Burial (b) Date thereof 8-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheffield

18. (a) Signature of funeral director J.P. Louis
(b) Address 3400 Woodlawn

19. (a) Aug. 12, 1940 (b) M. M. Crowe
(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 limits, write "RURAL")
(d) Street No. 620 Virginia
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 12
year 40 hour 2:00 minute 0 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 _____

Arteriosclerosis heart

Due to heart

Due to 95%

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 87%

23. Signature [Signature] (M. D. or other) _____
Address [Signature] Date signed 8/12/40

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.....
....., 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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.