DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 13 1941

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34056

Primary Registration District No. 100

Registrar's No. 3998

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

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: 0. (Specify whether

In this community: 53 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: JACKSON 048

(c) City or town: KANSAS CITY 3 8
(If outside city or town limits, write "RURAL")

(d) Street No. 3845 WYANDOTTE
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country: N

3. (a) PRINT FULL NAME: HERMAN EPSTEIN

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: MARRIED

6. (b) Name of husband or wife: MILDRED EPSTEIN

6. (c) Age of husband or wife if alive: 45 years

7. Birth date of deceased: JULY (Month) 4 (Day) 1888 (Year)

8. AGE: Years 53 Months 3 Days 22 If less than one day ... hr. ... min.

9. Birthplace: KANSAS CITY, MO (City, town, or county) (State or foreign country)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: ABRAHAM EPSTEIN
13. Birthplace: RUSSIA (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: FRADEL
15. Birthplace: RUSSIA (City, town, or county) (State or foreign country)

16. (a) Informant: MOE EPSTEIN
(b) Address: 4716 McGEE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 10-28-41 (Month) (Day) (Year)
(c) Place: burial or cremation: MT. CARMEL

18. (a) Signature of funeral director: J. P. LOUIS FUNERAL HOME
(b) Address: 3400 WOODLAND KC MO

19. (a) 10/27/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 26 year 1941 hour ... minute ... M.

21. I hereby certify that I attended the deceased from Jan 1941, 19..., to October 26, 1941 that I last saw him alive on October 26, 1941 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Subacute Bacterial Endocarditis (Streptococcus Viridans)	10 months
Due to: Rheumatic Heart Disease (Aortic Regurgitation)	30 yrs.
Due to:	
Other conditions: Marquee Right Foot (Include pregnancy within 3 months of death)	

Major findings:
Of operations: GJW
Of autopsy: As above.

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: Jack W. Kay (M. D. or other) M.D.
Address: Kansas City, Mo. Date signed 10-26-41

(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 Myself, Registered Apprentice No. ..... working under my personal supervision.

Signed Bert Legan

Licensed Embalmer No. 3.979

P. O. Address K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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

S. No. 2B
8-21-41

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34056

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3998

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

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: (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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Herman Epstein
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: July 4 1888 (Month) (Day) (Year)
8. AGE: Years 53 Months 3 Days 23 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation: Retired
11. Industry or business: Merchant
MOTHER FATHER
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) 10/27/42 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 26 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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)
(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY