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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

DEC 22 1941

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37611

Registrar's No. 4406

Primary Registration District No. 1002

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 _____ (Specify whether)
In this community 55 Years
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. 1010 East 27th
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Josephine Kahn Goldberg

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

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

6. (b) Name of husband or wife Joseph Goldberg 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 25 1846
(Month) (Day) (Year)

8. AGE: Years 95 Months 10 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation House Wife

11. Industry or business _____

12. Name Samuel Kahn

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

14. Maiden name Unknown

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

16. (a) Informant Sam Goldberg

(b) Address 1010 East 27th

17. (a) Burial (b) Date thereof 11-30-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mt. Carmel

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

(b) Address 3400 Woodland K. 6. Mo.

19. (a) 11-28-41 (b) M. M. Crown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 28
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from
Aug 16, 1941 to Nov 28, 1941
that I last saw her alive on Nov 26, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Uremic Poisoning
Due to Chronic Arteriosclerotic Nephritis

Due to Senility

Other conditions Fracture of Right Hip
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Aug 16, 1941
(c) Where did injury occur? Kansas City Jackson Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In her home
While at work? NO (Specify type of place) (e) Means of injury Fall

23. Signature J. W. Wray (M. D. or other) _____
Address Kansas City, Mo. Date signed 11-28-41

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

Dr. Jack Wolfe
Angyle

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.....

But Regan

Licensed Embalmer No. *3979*

P. O. Address: *H.C. No*

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.