. S. No. 2
0M—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 7 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5342

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 828

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: Trinity Lutheran Hosp (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Mo (Specify whether
In this community 2 mo. 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. 1906 E 31 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Michael Drew Stolor
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race Wn
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec (Month) 13 (Day) 1944 (Year)

8. AGE: Years 0 Months 2 Days 4 If less than one day hr. min.

9. Birthplace Kansas City (City, town, or county) Missouri (State or foreign country)
10. Usual occupation None
11. Industry or business
FATHER
12. Name Isadore Stolor
13. Birthplace (City, town, or county) Poland (State or foreign country)
MOTHER
14. Maiden name Sylvia Goldstein
15. Birthplace Kansas City (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Isadore Stolor
(b) Address K.C. Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Carmel Cem
18. (a) Signature of funeral director J.P. Louis Funeral Home
(b) Address K.C. Mo
19. (a) 2-19-45 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 17th year 1945 hour 12 minute 05 AM.
21. I hereby certify that I attended the deceased from Birth, 19, to Feb. 17, 1945; that I last saw him alive on Feb-16, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Staphlococcus Septicemae	3 weeks
Due to Prematurity	Life
Due to Secondary anaemia	4 weeks
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

159

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 Sydamon Waterball (M. D. or other)
Address 233 Plaza medical Bldg Date signed Feb 17 '45

(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. Lacuis.....

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

P. O. Address.....K.....

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.