

FILED APR 10 1945

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 96

1. PLACE OF DEATH:

(a) County: Calloway
(b) City or town: Fulton
(c) Name of hospital or institution: State Hosp No 19
(d) Length of stay: In hospital or institution 1 month 29 day
In this community: same

3. (a) PRINT FULL NAME: MINNIE BENJAMINE SIMON

3. (b) If veteran, name war: No. 3. (c) Social Security No.

4. Sex: female 5. Color or race: white 6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife: deceased 6. (c) Age of husband or wife if alive: 1837
7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years 87 Months Days If less than one day hr. min.

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

10. Usual occupation: housewife

MOTHER FATHER

11. Industry or business: 12. Name: DK
13. Birthplace: (City, town, or county) (State or foreign country)
14. Maiden name: DK
15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant: Records State Hosp No 1
(b) Address: Fulton Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 3 19 1945
(c) Place: burial or cremation: Kansas City Mo.

18. (a) Signature of funeral director: J. R. Roberg
(b) Address: Fulton Mo.

19. (a) 3-19-1945 (Date received local registrar) (b) Josie Abrahamoff (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City Mo.
(d) Street No.:
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: March day: 18 year: 1945 hour: 10 minute: P.M.

21. I hereby certify that I attended the deceased from March 14 1945 to March 18 1945 that I last saw her alive on March 18 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage Duration

Due to: Due to:

Other conditions: generalized atonic reflexes (Include pregnancy within 3 months of death)

Major findings: Of operations: Of autopsy: JBO

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?
(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

23. Signature: J. R. Roberg (M. D. or other) Address: Fulton Mo Date signed: 3/18/45

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

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RECEIVED
District Health Officer No. 9,

District File Number _____

Date Filed 4-9-45

APR 17 1945

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

J. J. Russell

Licensed Embalmer No. 2555

P. O. Address Hutton Mo

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.