

FILED SEP 14 1946

Primary Registration District No. 1002

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 6 DAYS
(Specify whether
In this community 48 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. 500 E. 8th ST.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME IKE POLANSKY

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 WIDOWED

6. (b) Name of husband or wife CELIA 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased JANUARY (?) 1860
(Month) (Day) (Year)

8. AGE: Years 86 Months 87 Days - If less than one day hr. min.

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

10. Usual occupation RETIRED PRODUCE DEALER

11. Industry or business -

MOTHER, FATHER { 12. Name (NOT KNOWN)
13. Birthplace RUSSIA
(City, town, or county) (State or foreign country)
14. Maiden name (NOT KNOWN)
15. Birthplace RUSSIA
(City, town, or county) (State or foreign country)

16. (a) Informant SAM POLANSKY

(b) Address 1700 E. 35th ST.

17. (a) BURIAL (b) Date thereof 8-29-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SHEFFIELD CEM.

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

(b) Address 3400 WOODLAND AVE., K.C., MO.

19. (a) 8-29-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 27
year 1946 hour 5 o'clock P. minute _____

21. I hereby certify that I attended the deceased from AUG 21
1946, to AUG 27, 1946;

(that I last saw him alive on AUG 27, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage,

Duration 6 hrs

Due to Post operative -
Transurethral resection of
prostate

Other conditions 137a
(Include pregnancy within 3 months of death)

Major findings: Hyperplasia - Prostate
Of operations Hemorrhage - retroperitoneal
Of autopsy obclusion common bile duct.

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 _____

23. Signature A.L. Stockwell (M. D. or other) MD
Address 625 Professional Bldg Date signed 29 Aug 1946

DR STOCKHILL

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..... *B. A. Legan*

Licensed Embalmer No..... *3979*

P. O. Address..... *K. C. 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.