

DEPARTMENT OF COMMERCE BUREAU OF VITAL RECORDS THE STATE BOARD OF HEALTH OF MISSOURI
FILED OCT 30 1946 STANDARD CERTIFICATE OF DEATH

30170

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4098

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:
2817 Wabash /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 32 Years
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
 (If outside city or town limits, write "RURAL") 8
 (d) Street No. 2817 Wabash
 (If rural, give location) 0
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Annie Bortnick

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 Married

6. (b) Name of husband or wife Daniel Bortnick 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Unknown
 (Month) (Day) (Year)

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

9. Birthplace Russia 1
 (City, town, or county) (State or foreign country)

10. Usual occupation House wife.

11. Industry or business _____

MOTHER FATHER { 12. Name Jacob Sherman 6

13. Birthplace Russia 6
 (City, town, or county) (State or foreign country)

14. Maiden name Ida Zalmonwitz

15. Birthplace Russia 6
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jack Newton

(b) Address 2817 Wabash, K. C., Mo.

17. (a) Burial (b) Date thereof 9-27-46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheffield Cemetery

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

(b) Address 3400 Woodland Ave., K. C., Mo.

19. (a) 9-28-46 (b) W. H. Hollman
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26
 year 1946 hour 11 minute 35 A.M.

21. I hereby certify that I attended the deceased from June 30, 1945, to Sept 26, 1946, that I last saw her alive on Sept 26, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary artery Disease. Myocardial Degeneration. Hypertension
 Due to _____
 Due to _____

Duration: 1 year
1 year
1 year

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
 Of autopsy _____
938

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 _____
 Signature W. H. Hollman (M. D. or other) MD
 Address 630 W. 14th Date signed 9/28/46

vi 2050
BY Signature

CECIL M. HODNY
WIFE. 23
VI. 1198

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. G. Legan

Licensed Embalmer No. 3979

P. O. Address H. 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.

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

5439

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Manassas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2817 Wabash
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Annie Bortnick
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 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 December 8, 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 9 18 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-28-46 (b) Stearldyne Holmes
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him/her alive on _____ 19 _____

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____ Of operations _____

Of autopsy _____

22. If death was due to natural 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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

MOTHER FATHER

Property classified. Exact statement of OCCUPATION: every important.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

3440

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County _____
 (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
 In this community _____ years, months or days)

3. (a) PRINT FULL NAME

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

4. Sex _____ 5. Color or race _____ 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 _____ (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

- MOTHER { 12. Name _____
 FATHER { 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County **30170**
 (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
 year _____ 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.

- Immediate cause of death _____
 Due to _____
 Due to _____

- Other conditions _____ (Include pregnancy within 3 months of death)

- Major findings:
 Of operations _____
 Of autopsy _____

Duration

PHYSICIAN

Underlines 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 _____ (M. D. or other) _____
 Address _____ Date signed _____