

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 149

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 hrs. 40 mins.
(Specify whether years, months or days) 45 years

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. 3015 Broadway Brooklyn
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah Siegel

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

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

6. (b) Name of husband or wife Sander 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased 1882
(Month) (Day) (Year)

8. AGE: Years 66 Months Days If less than one day
hr. min.

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

10. Usual occupation Housewife

11. Industry or business XX

12. Name Samuel Schere

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

14. Maiden name Chiah (unknown)

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

16. (a) Informant Betty Goldstein

(b) Address 1915 East 39th St.

17. (a) Burial (b) Date thereof 7-28-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheffield

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

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

19. (a) 7-27-48 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
year 1948 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from July 25, 1948, to July 26, 1948
that I last saw her alive on July 26, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to _____

Due to _____

Other conditions 830
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy None

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 W. W. Hart (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 7-26-48

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

MOTHER, FATHER

MT. 17124862

Dr. Strong

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 *Guy Buffington*
Licensed Embalmer No. *2256*
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.