S. No. 300
Rev. 10.48

FILED AUG 15 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28306

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3393

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (In this place): 1 Hr. 20m
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Menorah Hospital Medical Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 1205 E 59th St. 38 10

3. NAME OF DECEASED (Type or Print)
a. (First): Ernest
b. (Middle):
c. (Last): Spector

4. DATE OF DEATH (Month) (Day) (Year): 7-25-52

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12-15-1895
9. AGE (In years last birthday): 56
If under 1 year: Months / Days
If under 24 hrs.: Hours / Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: Grocer
11. BIRTHPLACE (City and State or Foreign Country): Russia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Louis Spector
13b. MOTHER'S MAIDEN NAME: Hattie Berkowitz
14. NAME OF HUSBAND OR WIFE: Tillie Spector

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME: Tillie Spector
ADDRESS: 1205 E 59 St.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

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19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/25, 1952, to 7/25, 1952, that I last saw the deceased alive on 7/25, 1952, and that death occurred at 7:50 A m., from the causes and on the date stated above.

23a. SIGNATURE: Paul Mobb
(Degree or title): M.D.
23b. ADDRESS: 1112 Bryant Bldg.
23c. DATE SIGNED: 7/26/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 27, 1952
24c. NAME OF CEMETERY OR CREMATORY: Sheffield
24d. LOCATION (City, town, or county) (State): Kansas City Mo.

DATE REC'D BY LOCAL REG.: 7-28-52
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE: Louis Funeral Home
ADDRESS: K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

_____, Student Embalmer No. _____,

working under my personal supervision.

Student _____
Student Embalmer

Signed Guy Buffington

Licensed Embalmer No. 2756

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.