

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28368
STATE FILE NUMBER

FILED AUG 30 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3782

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		Length of stay in 1b 45 yrs.	
3. NAME OF DECEASED (Type or print) First Minnie Middle Sporn Last Sporn		4. DATE OF DEATH Month August Day 11 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-98
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) New York City, N.Y.
13a. FATHER'S NAME TZVI KIRSCHBAUM		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE IRVING SPORN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT IRVING SPORN Address 7115 WALROND
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure - DUE TO (b) Chronic Passive Congestion - DUE TO (c) Diabetes Mellitus - Uremic State & Nephritis - 260K			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 1955 to August 11, 1957 and know her/him alive on 8-10-57 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE S. M. Shapard MD (Degree or title)		22b. ADDRESS 701 E 63 - Leub 201	22c. DATE SIGNED 8-11-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-12-57	23c. NAME OF CEMETERY OR CREMATORY Sheffield	23d. LOCATION (City, town, or county) (State) Kansas City Mo.
24. FUNERAL DIRECTOR J.P. Louis Funeral Home ADDRESS K.C. Mo.		25. DATE RECD. BY LOCAL REG. 8-12-57	26. REGISTRAR'S SIGNATURE Reva Minshall

L. M. Shapiro (USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE)

MEDICAL CERTIFICATION

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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
Signature of Student Embalmer

Signed *Henry Ruffington*

Licensed Embalmer No. 2756

P. O. Address *H. B. No.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.