

Health, Welfare, Public Service  
 000-5-56  
 All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 Morris Statland

FILED OCT 9 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER  
 32104

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4402

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b>			Length of stay in lb <b>45 yrs.</b>	d. STREET ADDRESS <b>5925 Paseo</b> (If outside, give location)	
3. NAME OF DECEASED (Type or print) First <b>Sam</b> Middle <b>Pollman</b> Last <b>Pollman</b>			4. DATE OF DEATH Month <b>September</b> Day <b>21</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-14-86</b>	9. AGE (In years last birthday) <b>70</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>egg company</b>	11. BIRTHPLACE (City and state or country) <b>Austria-Galicia 4</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Chiam Pollman</b>			14. MOTHER'S MAIDEN NAME <b>Gelle Berkowitz</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Sarah Pollman</b> Address <b>5925 Paseo</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hours</b> <b>8 years</b> <b>4200</b>
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. _____			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE		
21. I attended the deceased from <b>1949</b> to <b>9-21-1957</b> and last saw <del>her</del> him alive on <b>9/21/57</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Morris Statland M.D.</b>			22b. ADDRESS <b>701 E. 63rd St. Kc Mo.</b>		22c. DATE SIGNED <b>9/22/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>9/22/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>		
24. FUNERAL DIRECTOR <b>J. P. Louis Funeral Home</b> ADDRESS <b>K.C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9-22-57</b>	26. REGISTRAR'S SIGNATURE <b>Reva Minshall</b>		

(Licensed Embalmer's Statement on Reverse Side)



**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 *Guy Buffington* .....,  
Licensed Embalmer No. 275

P. O. Address *N. C. 7*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (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.