MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

11634

1. PLACE OF DEATH
County Jackson — Registration District No. 399
Township Kaw — Primary Registration District No. 1002
City Kansas City (No. General Hospital St. Ward)

File No.
Registered No.

2. FULL NAME Elizabeth Sorkin
(a) Residence. No. 415 Woodland St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U.S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Louis Sorkin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mh 1890

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
37	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House duties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia

PARENTS
10. NAME OF FATHER Hyman David Druker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Russia
12. MAIDEN NAME OF MOTHER Sarah Mh
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Russia

14. INFORMANT Louis Sorkin
(Address) 415 Woodland

15. FILED 4/4 1927 M. M. Crowe Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 3 1927

17. Coroner
I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.... that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental - Burns 1 & 2nd
A face, trunk and arms
(Towards line) Explosion
Turpentine & Wax (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Inspection
(Signed) H. E. Moss, M. D
4-3, 1927 (Address) Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Sheffield
DATE OF BURIAL: 4-4- 1927

20. UNDERTAKER: J. P. Louis
ADDRESS: 3400 Woodland

MAY 2 6 1949

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH

County.....

Township.....

City Kansas City (No.....,.....St. .....Ward)

Registration District No. 399

Primary Registration District No. 1002

File No.....

Registered No. 1434

2. FULL NAME Elizabeth Larkin

(a) Residence. No.....St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F.	Bl.	M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT.....
(Address)

15. FILED 4/4, 19 27 M. M. Crane Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 3 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above at.....m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Accidental burns 1st & 2nd degree trunk and arms by ~~[illegible]~~ gasoline explosion

Duration: ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) No burning bandage

Shock from turpentine on

Duration: ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED Home

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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