

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

Do not use this space.

37019

1. PLACE OF DEATH

County Jackson
Township Lawe
City Kennett, Mo. (No. 4317)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1011
St. _____ Ward)

2. FULL NAME

Rachel Libbie Kram

(a) Residence, No. 4317 Flora St. 15 Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U.S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Rubin

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

Unknown

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>65</u>			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home 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 Wolf Farber

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Russia

12. MAIDEN NAME OF MOTHER

Lylira Kivian

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Russia

14.

INFORMANT Joseph Kram
(Address) 4317 Flora

15.

FILED 12/22/27 M. M. Coroneo
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

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

12-21-1927

17.

I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to Dec 21, 1927 that I last saw her alive on Dec 24, 1927, and that death occurred, on the date stated above, at 3:3 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Insufficiency
(Chronic)

95B
11300 (duration) 20 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Decompensation
& Edema of Lungs (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. J. Gerovant, M. D.

12/22, 1927 (Address) 220 Argyle Bldg

*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

Mt. Carmel

DATE OF BURIAL

12-22-1927

20. UNDERTAKER

2 - ...

ADDRESS

City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH PERMANENT RECORD

