

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

Do not use this space.

13219

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 1549
 Township Raw Primary Registration District No. 1002 Registered No. 1549
 City Kansas City (No. Research Hosp.) St. _____ Ward _____

2. FULL NAME Caroline Greenbaum

(a) Residence. No. 5315 Virginia St., _____ 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? 25 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 George Greenbaum

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 16, 1889

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	38	11	19	

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) England

10. NAME OF FATHER Michael Goldenberg

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

12. MAIDEN NAME OF MOTHER Rose Sherman

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

14. INFORMANT George Greenbaum (Address) 5315 Virginia

15. FILED 45 28 Mo 28 1928 aw REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-3-1928

17. I HEREBY CERTIFY, That I attended deceased from 11:00 13- 1928, to April 3- 1928, that I last saw him alive on April 3- 1928, and that death occurred, on the date stated above, at 8:15 P. 1928.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary embolus -
Postoperative pneumonia
50.0 (duration) _____ yrs. _____ mos. 7- ds.
39.0 CONTRIBUTORY Systemic embolus - for fibrin
12 (SECONDARY) (duration) _____ yrs. _____ mos. 12 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 3/21/28

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Usual findings
 (Signed) OS Gubler, M. D.
4/4, 1928 (Address) Obey's 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 Sheffield Cem DATE OF BURIAL 4-6-1928

20. UNDERTAKER J. P. Lewis ADDRESS City

CAUSE OF DEATH in plain terms, so that it may be properly understood. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....

Registration District No. 399

File No.

Township.....

Primary Registration District No. 1002

Registered No. 1549

City Kennett No.

St.

Ward)

2. FULL NAME.....

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-3 19 28

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

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:

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

Primary embolus
Post operative pneumonia

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.....

CONTRIBUTORY (SECONDARY) not malignant Hysterectomy for fibrous uterine (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) B. B. Beck..... M. D.

, 19 (Address) Angie Beck

*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.

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)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 4/5 19 28 S. M. Crave REGISTRAR

20. UNDERTAKER ADDRESS

SHALL NOT RECEIVE A FEE FOR C... ICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW... ly classified. Exact statement of OCCUPATION is very important. THE in plain terms, so that it may b

SUPPLEMENTARY

S-13219