

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

Do not use this space.

17183

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. St. Joseph Hosp)

Registration District No. 399

Primary Registration District No. 1002

File No. 17183
Registered No. 17183
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 4201 Wabash St.,
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. 15 da. Ward _____
How long in U.S., if of foreign birth? 25 yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Soldie Baum

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 7, 1880

7. AGE YEARS 47 MONTHS 10 DAYS 11 IF LESS THAN 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) 103
(c) Name of employer Self.

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

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

14. INFORMANT (Address) Joseph Baum
4201 Wabash

15. FILED 5716 19 28 M.M. Cosrove REGISTRAR
Asor

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-15-1928

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1928, to May 15, 1928, that I last saw him alive on May 15, 1928, and that death occurred, on the date stated above, at 7 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Secondary Renoscalage
following septicaemia
(duration) _____ yrs. _____ mos. 1 da.
CONTRIBUTORY Typhlo-nephritis
(SECONDARY) (duration) 10 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF May 15

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Alivise

(Signed) Frank Cosrove, M. D.
5716, 1928 (Address) 428 Maple 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 DATE OF BURIAL 5-16-1928

20. UNDERTAKER J.P. Lewis 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.

PERMANENT RECORD

THIS IS A PENDING INK—

**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.....
Township.....
City..... (No.)

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 2153
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

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

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 5/16/28 M.M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15 1928

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.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

Secondary hemorrhage following nephrectomy operation was done for pyelonephritis.
CONTRIBUTORY (SECONDARY) Pyelonephritis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRIBUTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH DATE OF

WHAT TEST CONFIRMED DIAGNOSIS

Frontal x-rays, M. D. (Address) 928 U.S. 6 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

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

J.P. Lewis

WRITE PLAINLY, WITH UNFADING INK---THIS IS A SUPPLEMENTARY RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, & may be properly classified. Exact status of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-17188