

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

Do not use this space.

1475

1. PLACE OF DEATH

County Jackson Registration District No.
 Township Kaw Primary Registration District No.
 City Kansas City (No. 3533, Virginia) St. Ward

File No.
 Registered No. 62
 St. Ward

2. FULL NAME

Bessie Silverman

(a) Residence. No. 3533 Virginia St., 13 Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 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 David Silverman

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>66</u>	<u>?</u>	<u>?</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) Poland

10. NAME OF FATHER Theodore Paritz

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT David Silverman (Address) 3533 Silverman

15. FILED 16-29 M.M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 1929

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that

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:

Rupture heart
95B
93011

CONTRIBUTORY Chronic myocarditis (SECONDARY) (duration) 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? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Danley, M. D.

1/4, 1929 (Address) Deputy 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 Mt. Carmel DATE OF BURIAL 1-6-1929

20. UNDERTAKER J. P. Louis ADDRESS Kan City, Mo

PHYSICIANS should file this certificate with the Registrar. It is a criminal offense to falsify or to withhold information. It is very important that it be filed in the proper manner.

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CONFIDENTIAL

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**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
 Township N. City Primary Registration District No. 1002
 City..... (No.)..... St. Ward)

2. FULL NAME Bessie Silverman
 (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 F | **4. COLOR OR RACE** W | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** 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 7/6 19 29 M. M. Crowe REGISTRAR
Assy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jun 4 19 29
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:
ruptured heart
cause unknown
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
gaa
 (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.....

WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) Shelley G. Hall, 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

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
 N. B. Every entry should be carefully checked for accuracy. PHYSICIANS should state CAUSE OF DEATH in plain terms.
 REGIS ARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LA

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