

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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 3609 Benton Blvd)

Registration District No. 399
Primary Registration District No. 1002

File No. 1487
Registered No. 75
St. 4th Ward

2. FULL NAME

Felix Levy
(a) Residence. No. 3609 Benton Blvd St. 4th Ward.

(Usual place of abode)
Length of residence in city or town where death occurred 53 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 11 1875

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
52 8 24 = min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Brokerage
(b) General nature of industry, business, or establishment in which employed (or employer) Employer
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Louis Levy

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

12. MAIDEN NAME OF MOTHER Dont Know

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

14. INFORMANT Mrs. Cora Levy
(Address) 3609 Benton Blvd

15. FILED 11 29 M M. Grover
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1929

17. I HEREBY CERTIFY, That Deputy Coroner attended deceased from 1929 to 1929, and that I last saw him alive on 1929, and that death occurred, on the date stated above, at 1929.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
131
930

CONTRIBUTORY Chronic interstitial nephritis (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF BIRTH, DATE OF 1929

DID AN OPERATION PRECEDE DEATH? No DATE OF 1929

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Deputy Coroner M. D.

1/5 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 Elmwood DATE OF BURIAL 1/8/1928

20. UNDERTAKER Julian K Davidson ADDRESS City, Mo

3

1

• •

42

Figure 1

**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. 75

City St. City (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

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)

Apr 11 - 1876

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

52 8 24

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

1/7 29 St. M. M. Brown

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Jan 5 1899

17.

I HEREBY CERTIFY, That I attended deceased from

19...., to 19...., 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:

CONTRIBUTORY (SECONDARY)

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)....., 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

PERMANENT

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

AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. to that it may be properly classified.

S-1487