

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 Law
City Law (No. _____)

Registration District No. **399**
Primary Registration District No. 1003

File No. 2221575
Registered No. 253
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 206 St. Law Ward. _____
(Usual place of abode)

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 4, 1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 2 1 9

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Samuel Lerner

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Robert D. Lerner
(Address) 400 N. 61st Terr.

15. FILED 1-13-29 M. M. Crowe
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 13 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-2 1929, to 1-13 1929, that I last saw him alive on 1-13 1929, and that death occurred, on the date stated above, at 1:05 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility
Cardio-renal.
(duration) yrs. mos. ds. 6 mos. 2 ds.
CONTRIBUTORY (SECONDARY) Hypertension
Alcohol (duration) yrs. mos. ds. 2 ds.

18. WHERE WAS DISEASE CONTRACTED Topeka Kansas
IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Examination

(Signed) M. M. Crowe M. D.
(Address) Kansas City Mo.

*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 Salina Kan DATE OF BURIAL Jan 14 1929

20. UNDERTAKER D. W. Newcomer ADDRESS _____

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