

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

Do not use this space.

8771

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1000
 City Kansas City (No. 3240 Michigan) St. _____ Ward _____

File No. _____
 Registered No. 1049

2. FULL NAME Louis Wolfberg

(a) Residence. No. 3240 Michigan St. 13 Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U.S., if of foreign birth 22 yrs. mos. ds. (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
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Wolfberg

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unk 1840

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	90			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Merchant

(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) Lithiania

PARENTS	10. NAME OF FATHER <u>Simon Wolfberg</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Lithiania</u>
	12. MAIDEN NAME OF MOTHER <u>Not Known</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Not Known</u>

14. INFORMANT Chas. Wolfberg
 (Address) 3801 So. Benton

15. FILED 3/14, 1930 M. M. Bruce
 REGISTRAR
Acst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 13, 1930

17. I HEREBY CERTIFY, That I attended deceased from Mich 1, 1930, to Mich 12, 1930, that I last saw him alive on Mich 12, 1930, and that death occurred, on the date stated above, at 3:00 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic cardiovascular disease

75/100 (duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) decompensation
small vessel (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? no

WHAT TEST CONFIRMED DIAGNOSIS Physiical signs & sym.
 (Signed) R. J. Sloman, M. D.
Mich 14, 1930 (Address) Rolls 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 Mt. Carmel Cemetary DATE OF BURIAL March, 16, 1930

20. UNDERTAKER P. Louis Funeral Director ADDRESS City, Mo

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

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.

