

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

Do not use this space.

16115

1. PLACE OF DEATH **399**
 County Jackson Registration District No. 1002
 Township Kaw Primary Registration District No. 2023
 City Kansas City (No. Research Hospital) St. _____ Ward _____

2. FULL NAME Sam Friedman
 (a) Residence No. 5142 Paseo St. 15 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 **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 Rose Friedman

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 '81

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) Merchant
 (c) Name of employer

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

10. NAME OF FATHER Not Known Friedman

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Ruby Friedman
 (Address) 5142 Paseo

15. FILED 5/11 1930 M. M. Lawrence REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10 1930

17. I HEREBY CERTIFY, That I attended deceased from May 1 1930, to May 10 1930, that I last saw him alive on May 10 1930, and that death occurred, on the date stated above, at 4:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

82 A
Apoplexy 97
102 (duration) yrs. mos. ds.
 CONTRIBUTORY Arteriosclerosis and arterial
 (SECONDARY) Hypertension (duration) unknown 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? No
 WHAT TEST CONFIRMED DIAGNOSIS? Paralysis
 (Signed) Carl K. Ferris, M. D.

May 11 1930 (Address) 934 Angyle 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 Cem DATE OF BURIAL 5-11 1930

20. UNDERTAKER J. P. Louis ADDRESS K. C. 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.

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