

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

Do not use this space.

19482

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kaw Primary Registration District No. _____
City Kansas City (No. St. Joseph Hospital) St. _____ Ward _____

File No. 2-17
Registered No. 6-18
St. _____ Ward _____

2. FULL NAME Nathan Comens

(a) Residence. No. 3119 Michigan Ave. St. 13 Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth 10 yrs. 0 mos. 0 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) Single	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 3, 1907			
7. AGE YEARS 22	MONTHS 9	DAYS 9	IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Salesman**

(b) General nature of industry, business, or establishment in which employed (or employer) **General Wdse.**

(c) Name of employer **Father**

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) **Poland**

10. NAME OF FATHER **Sammel Comens**

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

12. MAIDEN NAME OF MOTHER **Sarah Weinstein**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) **Poland**

14. INFORMANT Miss. Freida Comens
(Address) 3119 Michigan Ave.

15. FILED 6/12 1930 W. M. Korb
REGISTRAR ant

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 12, -30 19**

17. I HEREBY CERTIFY, That I attended deceased from June 10th, 1930, to June 12th, 1930 that I last saw him alive on June 12th, 1930, and that death occurred, on the date stated above, at 11:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute Hemorrhagic meningitis (non-epidemic)
7914 (duration) _____ yrs. _____ mos. 2 ds.

CONTRIBUTORY (SECONDARY) 7100
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH, 3119 Michigan

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS spinal punctate
(Signed) Joseph Sulemson, M. D.
6-13, 1930 (Address) 1219i Reolto 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 Cemetary** DATE OF BURIAL 6-15-1930

20. UNDERTAKER **J.P. Louis, Funeral Director, City.** ADDRESS _____

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.

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

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