

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

Do not use this space.

22897

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Kearney Primary Registration District No. 1002  
 City Kansas City (No. Kansas City Gen Hosp) St. Mo Ward

**2. FULL NAME**

Rebecca Abramowitz  
 (a) Residence, No. 2711 Brighton St., 17 Ward. (If nonresident, give city or town and State)  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U.S., if of foreign birth? 29 yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 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 Joseph Abramowitz

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 15, 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
49 5 28

8. OCCUPATION OF DECEASED Housewife  
 (a) Trade, profession, or particular kind of work. 59  
 (b) General nature of industry, business, or establishment in which employed (or employer). 1396  
 (c) Name of employer

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

10. NAME OF FATHER Isaac Goldstein

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

12. MAIDEN NAME OF MOTHER Minnie Abraham

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

14. INFORMANT Rebecca Clark (Address) K.C. General Hosp.

15. FILED 7/14, 1930 M. M. Crowe REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-13 1930

17. I HEREBY CERTIFY, That I attended deceased from 7-6 1930 to 7-13 1930 that I last saw her alive on 7-13 1930 and that death occurred, on the date stated above, at 7:55 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Post operative shock following operation for cervical polyps & Pap. Hysterectomy  
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Audosis  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 7-10-30

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) P. E. Williams, M. D.

7-13, 1930 (Address) Sept K.C. Gen. Hosp

\*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 DATE OF BURIAL 7-15-30

20. UNDERTAKER J. T. Lewis ADDRESS 64 City, Mo

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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Jr.

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

24216

**1. PLACE OF DEATH**

County..... Registration District No. 399 File No.....  
 Township..... Primary Registration District No. 1002 Registered No. 2889  
 City K. City (No.....) St. .... Ward)

**2. FULL NAME**

Rebecca Abramovitz  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 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)

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

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 7/14/30 M. M. Brown REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/13 1930

17. I HEREBY CERTIFY That I attended deceased from .....  
 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:  
Post operative shock following operation for cervical polyps (not malignant) (Pan Hysterectomy)  
 (duration)..... yrs. .... mos. .... da.

CONTRIBUTORY acidosis, diabetic (SECONDARY) (duration)..... yrs. .... mos. .... da.

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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

57

N. B.—Every item of information should be carefully supplied. AGES 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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