

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

Do not use this space.

30147

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township Kaw Primary Registration District No. 1002  
City Kansas City (No. St. Joseph Hospital)

File No. \_\_\_\_\_  
Registered No. 3955  
St. \_\_\_\_\_ Ward)

**2. FULL NAME** Jacob Hyman

(a) Residence No. 4219 Harrison St. 6 Ward. \_\_\_\_\_  
(Usual place of abode)  
Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U.S., if of foreign birth? 32 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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Hyman

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 50

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Pawn Broker  
(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) Poland

10. NAME OF FATHER Hymie Hyman

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

12. MAIDEN NAME OF MOTHER Rachael -

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

14. INFORMANT Mrs. Anna Hyman  
(Address) 4219 Harrison

15. FILED 9/28/30 M.M. Brown REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-27-30 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 24, 1930, to Sept 27, 1930 that I last saw him alive on Sept 27, 1930, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Haemorrhage from gastric ulcer

Ulcer history about 10 yrs. duration

CONTRIBUTORY gastric enterostomy (SECONDARY) manipulation more than likely resulting in haemorrhage (duration) \_\_\_\_\_ yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, \_\_\_\_\_  
DID AN OPERATIVE PRECEDENT DEATH? Yes DATE OF Sept 26-30  
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Chemical  
(Signed) J.P. Rose M. D.

9/28, 1930 (Address) 978 Crayle 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 9-28-30, 1930

20. UNDERTAKER J.P. Louis Funeral Home ADDRESS 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.

