

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

Do not use this space.

36418

1. PLACE OF DEATH

County Jackson Registration District No. 5
Township Kaw Kansas City Primary Registration District No. 5
City Kansas City (No. 5446) Charlotte St. _____ (Ward)

File No. 4000
Registered No. 4000

2. FULL NAME

Samuel Kantor
(a) Residence. No. 5446 Charlotte St. 6 Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 50 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) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Kantor

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
80 - - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rabbi
(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) Russia

PARENTS

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT Mrs. I. D. Rubin
(Address) 5446 Charlotte St.

15. FILED 11/30 1930 M. M. Crouse REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 28, 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 28, 1930 that I last saw h. a. r. alive on Nov 27, 1930, and that death occurred, on the date stated above, at 7 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

a Angina Pectoris
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Myocard Regurgitatio
(duration) 60 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IS NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Symptoms
(Signed) H. J. Germain M. D.
11/29, 1930 (Address) Mrs. Angyle Bly

*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 11-30-30

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

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.

