

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

Do not use this space.

1528

1. PLACE OF DEATH

County Jackson Registration District No. 303
 Township East Primary Registration District No. 303
 City Kansas City (No. 6200 Harrison) St. _____ Ward _____

File No. _____
 Registered No. 300
 St. _____ Ward _____

2. FULL NAME

Ceyla Brooks
 (a) Residence. No. 6200 Harrison St. 8 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 female 4. COLOR OR RACE Jewish 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-30-1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73. | 9 | 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home work
 (b) General nature of industry, business, or establishment in which employed (or employer) 933
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Russia
 (STATE OR COUNTRY) 23

10. NAME OF FATHER Abraham Levine

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

12. MAIDEN NAME OF MOTHER Ceyla Levine

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

14. INFORMANT Mr. D. Sullivan
 (Address) 6200 Harrison KC Mo

15. Jan 25, 1931 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 24 - 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan. 17 - 1931, to Jan. 24 - 1931.
 That I last saw h. a. l. alive on Jan. 24, 1931, and that death occurred, on the date stated above, at 3:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis, chronic
24 15 (duration) 0 yrs. 0 mos. 0 da.
93C

CONTRIBUTORY (SECONDARY) Cirrhosis of Liver
 (duration) _____ yrs. _____ mos. _____ da.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) M. M. Crowe, M. D.

1-25-1931 (Address) 61647 Paseo

*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 Cemetery DATE OF BURIAL Jan 25 1931

20. UNDERTAKER H. Pigeon + bus ADDRESS KC. 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.

WRITE PLAINLY, WITH ONLY ONE WRITING.

