

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

Do not use this space.

17898

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399
Primary Registration District No. E 8th 1002

File No. _____
Registered No. 235
St. _____ Ward _____

2. FULL NAME

Fessell Lipkin

(a) Residence. No. 2616 E 8th St. St. 11 Ward. _____

Length of residence in city or town where death occurred 14 yrs. - mos. - ds. - How long in U. S., if of foreign birth? 14 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M.</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Fessell Lipkin</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jul 10 1867</u>		
7. AGE	YEARS <u>63</u>	MONTHS <u>9</u>
	DAYS <u>22</u>	IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House duties
(b) General nature of industry, business, or establishment in which employed (or employer). 235
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

Russia (STATE OR COUNTRY) 23

PARENTS

10. NAME OF FATHER Samuel Mainz
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Russia
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Russia

14.

INFORMANT Fessell Lipkin
(Address) 2616 E 8th St.

15.

FILED 5/3 31 1931 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-2 1931

17. I HEREBY CERTIFY, That I attended deceased from May 1 1931 to May 2 1931
that I last saw him alive on May 2 1931 and that death occurred, on the date stated above, at 6:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
8:20
10:20 (duration) yrs. mos. ds.
CONTRIBUTORY Hypertension
(SECONDARY) unknown (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

9 DID AN OPERATION PRECEDE DEATH? ? DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? usual

(Signed) John E. Robinson, M. D.
5-3-31 (Address) 570 Altman 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 Cemetery DATE OF BURIAL 5-3-1931

20. UNDERTAKER

J. T. Lewis ADDRESS 3400 Woodland Ave.

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.

