

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City (No.           )

Registration District No. 329  
Primary Registration District No. 1002  
Research Hospital

File No. 35956  
Registered No. 4466  
St.            Ward           

**2. FULL NAME** Samuel L. Fine

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</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>Litha Fine</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec. 4, 1880</u>		
7. AGE YEARS <u>51</u>	MONTHS <u>11</u>	DAYS <u>24</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>mail carrier</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>530</u>		
10. Date deceased last worked at this occupation (month and year) <u>          </u>		11. Total time (years) spent in this occupation <u>87 1/2</u>

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

13. NAME Not known

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

17. INFORMANT Mrs. Samuel L. Fine  
(ADDRESS) Nevada, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Nevada, Mo. DATE 11/29 1932

19. UNDERTAKER Thine F. McClure  
(ADDRESS) 3235 Hillbarn Place

20. FILED Nov 28 1932 M. M. Coram  
Asst. Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 28, 1932

22. I HEREBY CERTIFY, That I attended deceased from November 24, 1932 to November 28, 1932  
I last saw him alive on November 28, 1932 Death is said to have occurred on the date stated above, at 5 A. m.

The principal cause of death and related causes of importance were as follows:  
Brain tumor, right temporal and occipital lobes.  
(Duration indefinite; history 1 month)  
Date of onset           

Other contributory causes of importance:  
Spontaneous (apoplectic) intracerebral hemorrhage 8 hours.

Name of operation Decompression Date of Nov. 27, 1932  
What test confirmed diagnosis? operation Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?            Date of injury           , 19            
Where did injury occur?            (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury             
Nature of injury           

24. Was disease or injury in any way related to occupation of deceased? No.  
If so, specify             
(Signed) Frank R. Deachenor, M. D.  
(Address) 1002 Argyle Bldg

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No. 4466  
 City..... (No. Research Hospital St. .... Ward)

**2. FULL NAME** Samuel L. Fine  
 (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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** M.  
**4. COLOR OR RACE**  
**5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word)  
**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.  
51

**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** 11/28 3<sup>rd</sup> M. M. Crowe  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 11-28-1932  
**17. I HEREBY CERTIFY**, That I attended deceased from ..... 19....., to ..... 19..... 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:  
Brain tumor  
Lithoma, infiltrating  
Cervical lymph node  
 (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY)  
530  
 (duration) ..... yrs. .... mos. .... ds.

**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) Faulk Rechner, M. D.  
 , 19 (Address) 1000 Arroyo Blvd

\*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  
 19

**20. UNDERTAKER** ADDRESS

N. B.—Every item of information should be carefully checked. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATION UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

800 1000 1500