

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

OCT 17 1934

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township KEW
City Kansas City

Registration District No. 300
Primary Registration District No. 400 E
(No. Research Hospital)

File No. 33019
Registered No. 1358
St. _____ Ward _____

2. FULL NAME Jake Hetman

(a) Residence, No. 2531 Olive 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 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 Deceased

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
Approx 60

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Jeweler

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

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

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT Gertrude Bitwin
(ADDRESS) Chanute Ks.

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge DATE Sep 26, 34

19. UNDERTAKER H. TIGERMAN & SON'S
(ADDRESS) _____

20. FILED 9-26-34 M. M. Crowe
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 24 1934

22. I HEREBY CERTIFY, That I attended deceased from Sept 12 1934, to Sept 24 1934

I last saw him alive on Sept 24 1934 Death is said

to have occurred on the date stated above, at 7:27 p.m.

The principal cause of death and related causes of importance were as follows:

Cerebral Thrombosis Date of onset 9/12

Other contributory causes of importance:

Hypostatic Pneumonitis 9/20

Name of operation _____ Date of _____

What test confirmed diagnosis? Tests of Amylops as there an autopsy? No

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 _____

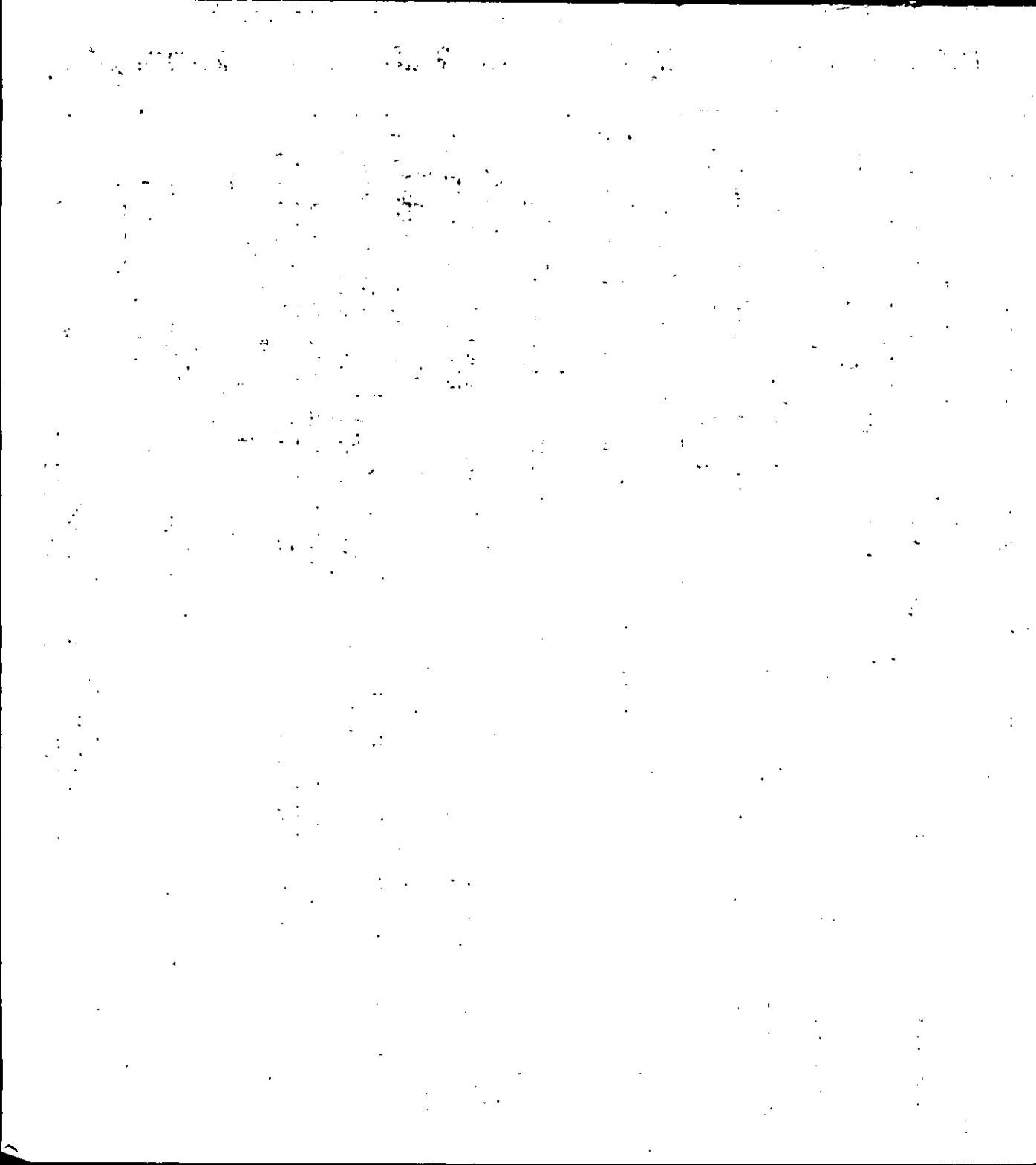
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) N. D. Jerovick, M. D.

(Address) 221 W. 4th Bldg.



Kansas City

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Jake Helman
Who died at Research Hosp on Sept 24 - 1934
Residence: No. 2531 Olive St. K.C. Mo.
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex m Color or race W Single, married, widowed or divorced: _____

Date of birth about 1874 Age: Years 60 Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Jeweler
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. Jewelry Store

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: _____

Other contributory causes of importance Hypostatic pneumonia - Lobular & Interstitial?

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No
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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician H. D. Jerauwitz
Address of physician 225 Argyle Bldg
Signature of Registrar M. M. Crowe Date filed 9/26/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. _____
Primary Reg. Dist. No. _____

Very truly yours,
E. T. McGaugh
State Registrar

Special Agent.

S-33019