

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

Do not use this space.

NOV 13 1934

36110

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City (No. \_\_\_\_\_)

Registration District No. 399  
Primary Registration District No. 1007  
517 E. 18th. St.

File No. \_\_\_\_\_  
Registered No. 4613  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Zalman Adelman

(a) Residence, No. 3825 Paseo 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) Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 15, 1886

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>48</u>	<u>5</u>	<u>1</u>	

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

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

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 Joseph Adelman

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

15. MAIDEN NAME Unknown

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

17. INFORMANT Max Zarnow (ADDRESS) 1406 E 39th.

18. BURIAL, CREMATION, OR REMOVAL PLACE Sheffield Cem. DATE 10/17 34

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

20. FILED 10/17 1934 M. M. Carome Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/6/34

22. I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_, 19\_\_\_\_

I last saw him live on \_\_\_\_\_, 19\_\_\_\_ Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows: \_\_\_\_\_ Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_  
If so, specify \_\_\_\_\_ (Signed) \_\_\_\_\_, M. D.  
(Address) \_\_\_\_\_

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.

MOTHER FATHER OCCUPATION

*Handwritten notes and signatures:*  
1  
21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/6/34  
22. I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_, 19\_\_\_\_  
I last saw him live on \_\_\_\_\_, 19\_\_\_\_ Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows: \_\_\_\_\_ Date of onset \_\_\_\_\_  
Other contributory causes of importance: \_\_\_\_\_  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
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? \_\_\_\_\_  
If so, specify \_\_\_\_\_ (Signed) \_\_\_\_\_, M. D.  
(Address) \_\_\_\_\_

