

Apr 22 1935

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

Do not use this space.

12888

1. PLACE OF DEATH

County Jackson
Township Home
City Kansas City (No. Manoral Hosp)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1500
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 3622 Tracy St. _____ Ward _____

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE W.G. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Not known

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64

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

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 Hyman Seigel

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

15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT Henry Dworakowitz (ADDRESS) 3622 Tracy

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Bernard DATE Apr 14, 1935

19. UNDERTAKER (ADDRESS) St. Louis Funeral Home

20. FILED 4-14 1935 M. J. Crowe, asst. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-12-1935

22. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1934, to April 12, 1935

I last saw h. aw alive on April 12, 1935 Death is said to have occurred on the date stated above, at 9:30 P. m.

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

Coronary obelusion. Acute, extension of previous Nteri.

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Yes 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. 2

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

(Signed) Dore Key M. D.
(Address) 1610 Bay Blvd, St. Louis

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.

