

23 1936

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

Do not use this space.

39486

1. PLACE OF DEATH

County Jackson Registration District No. 399 ✓  
Township Kearney Primary Registration District No. 1002  
City Kansas City (No. Memorial Hosp) St. Ward  
Registered No. 4622

2. FULL NAME

(a) Residence, No. 4434 Benton St., Ward. (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 Female 4. COLOR OR RACE W.C. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 1, 1935  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
0 0 7

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child  
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) D.C.

13. NAME Hermann Sias

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

15. MAIDEN NAME Sarah Klutznick

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

17. INFORMANT (ADDRESS) Hermann Sias 4434 Benton

18. BURIAL, CREMATION, OR REMOVAL PLACE Sheffield Cem DATE 12-5-1935

19. UNDERTAKER (ADDRESS) P. Lewis Funeral 3420 Woodland

20. FILED 12/5 1935 M.M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-5-1935

22. I HEREBY CERTIFY, That I attended deceased from December 1, 1935 to Dec 5, 1935. I last saw her alive on Dec 4, 1935. Death is said to have occurred on the date stated above, at 8 A.M. The principal cause of death and related causes of importance were as follows:

Aspiration Pneumonia Date of onset

Other contributory causes of importance

Name of operation None Date of None  
What test confirmed diagnosis? Phys. Ex. Was there an autopsy? No

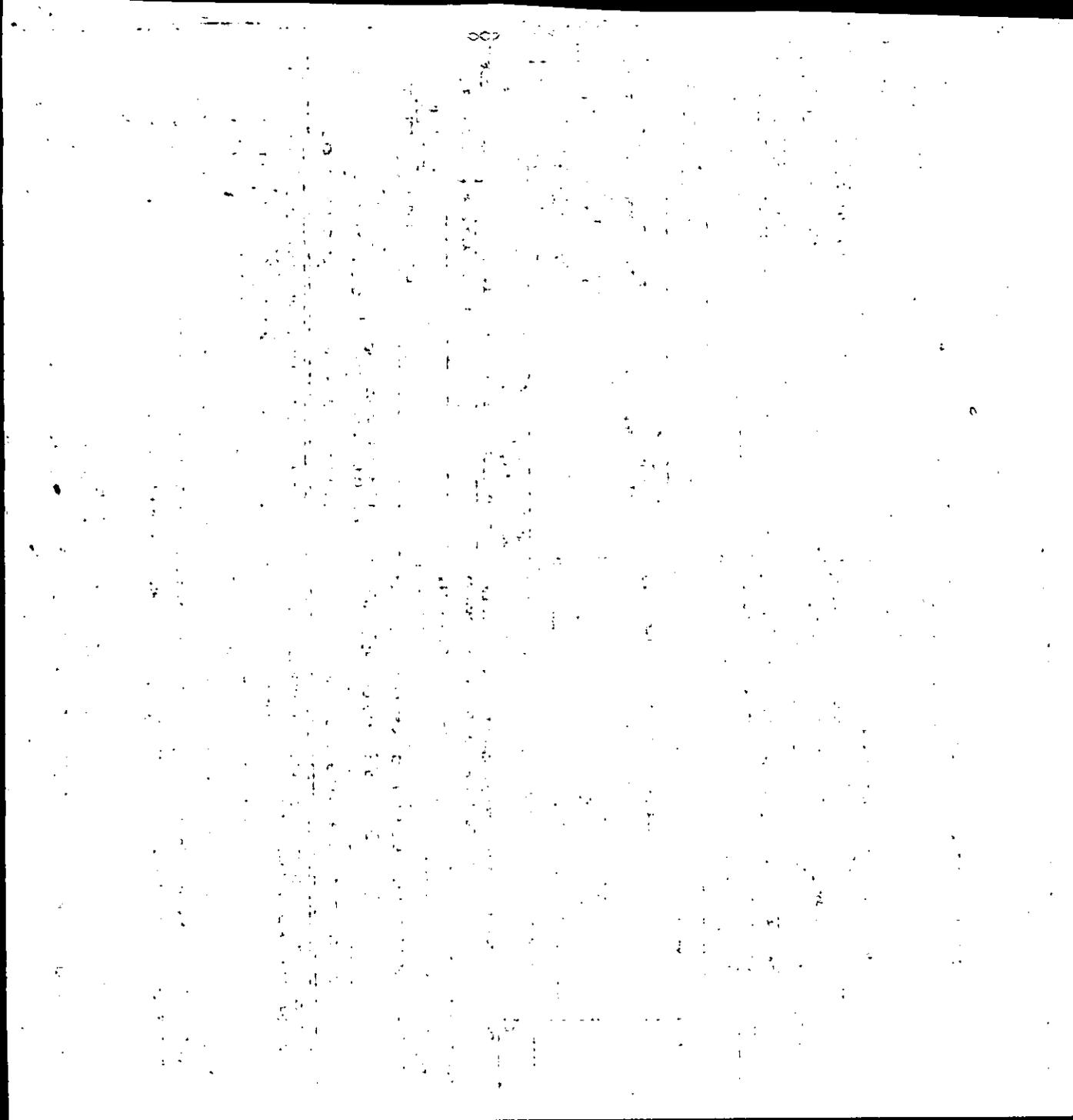
23. If death was due to external causes (violence), fill in also the following: accident, suicide, or homicide? Date of injury, 19...

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? If so, specify

(Signed) J. H. Shapiro M. D.  
(Address) 230 A. J. Bldg.



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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson

Registration District No. 399

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 1002

Registered No. 4622

City Kansas City (No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

**2. FULL NAME**

Infant Lisa Anna

(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 7    4. COLOR OR RACE W    5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (Write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 1 - 35

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
			<u>4</u>	

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

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) \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL  
PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 17 1936 M. M. Brown Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12 - 5 - 1935

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

I last saw him alive 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:

Aspiration Pneumonia    Date of onset \_\_\_\_\_

Other contributory causes of importance: Premature Birth

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), file 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) L. W. Shopshire M. D.

(Address) 220 Argyle Bldg

SUPPLEMENT

S-394186