

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

Do not use this space.

45035

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City M.C. (No. Memorial Hosp) St. _____ Ward _____

File No. _____
 Registered No. 5210

2. FULL NAME

(a) Residence, No. 2417 Troost, 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 Ma 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>April 65</u>	<u>2</u>	<u>2</u>	<u>2</u>	

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

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 Simon Stein (ADDRESS) 2709 Brighton

18. BURIAL, CREMATION, OR REMOVAL PLACE McConnell DATE 11-29-19

19. UNDERTAKER N. T. Tigerman & Son (ADDRESS) M.C., Mo.

20. FILED Dec 29, 19 M. M. Corone Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____, 19____

22. I HEREBY CERTIFY, That I attended deceased from Nov, 1928, to Dec 28, 1928

I last saw him alive on Dec 28, 1928. 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:

Osteo-myelitis, left humerus

Date of onset 3 mo

Other contributory causes of importance: Arterio-sclerosis ?

Name of operation amputation of hand of finger Date of _____

What test confirmed diagnosis? _____ 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____

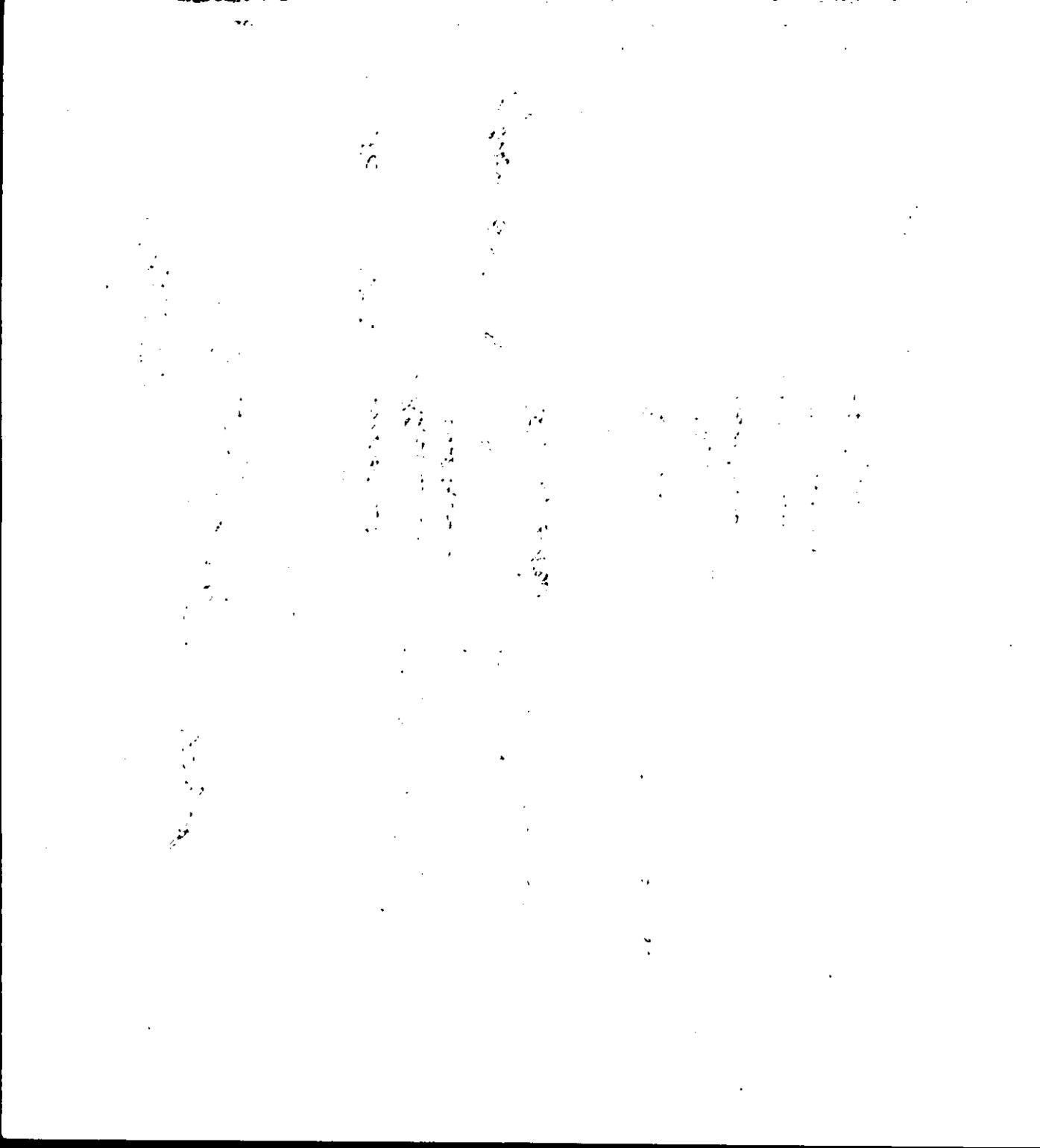
Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

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

(Signed) H. Schaefer M. D.
 (Address) 1405 Bryant 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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1. PLACE OF DEATH

County Jackson

Registration District No. 399

File No. _____

Township _____

Primary Registration District No. 1002

Registered No. 5619

City X. E. Mo (No. _____)

St. _____ Ward _____

2. FULL NAME Salomon White

(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 W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11/11/04

7. AGE

YEARS 65

MONTHS _____

DAYS _____

If LESS than 1 day, _____ hr. or _____ min.

OCCUPATION

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)

MOTHER FATHER

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 1729 1936 M. M. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 28 1936

22. I HEREBY CERTIFY That I attended deceased from _____, 19____, 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:

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) J. H. Schaefer, M. D.

(Address) 1405 - 13th St. 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.

SUPERINTENDENT

5-49035