

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

Do not use this space.

**MAY 15 1937**

**15327**

**1. PLACE OF DEATH.**

County Jackson Registration District No. 399  
 Township Kan Primary Registration District No. 1002  
 City Kansas City (No. 2843, Throost) St. \_\_\_\_\_ Ward \_\_\_\_\_

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

**2. FULL NAME**

Joseph B. Levine

(a) Residence, No. 2843 Throost 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Rebecca Levine</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Unknown</u>		
7. AGE YEARS <u>74</u>	MONTHS <u>-</u>	DAYS <u>-</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Retired</u>		If LESS than 1 day, _____ hrs. or _____ min.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>-</u>		11. Total time (years) spent in this occupation
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Russia</u>		
13. NAME <u>Not known</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u>		
15. MAIDEN NAME <u>Not known</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u>		
17. INFORMANT (ADDRESS) <u>Morton Brown</u> <u>A. C. M.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Sheffield Cem.</u> DATE <u>4-20-1937</u>		
19. UNDERTAKER (ADDRESS) <u>Phoyis Funeral Home</u> <u>3400 Woodland Ave</u>		
20. FILED <u>Apr 20 1937 M. M. Brown</u> Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-18-1937

22. I HEREBY CERTIFY that I attended deceased from Wed 18 to 18 April, 1937  
 I last saw him alive on April 18, 1937. Death is said to have occurred on the date stated above, at 6 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Scillet  
Chr. Myocarditis  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: 1st  
Spontaneous Myocardium  
with Myocarditis; Chronic  
 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. B. Brown M. D.  
 (Address) 306 E 12 St

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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**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  
 Township Kansas City Primary Registration District No. 1002  
 City Kansas City (No. 2843) Roost St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 15327  
 Registered No. 1873

**2. FULL NAME**

Joseph B Levine  
 (a) Residence, No. 2843 Roost 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)

7. AGE YEARS 74 MONTHS \_\_\_\_\_ DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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 4/20 1937 M. A. Growe Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 18 . 1937

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

I last saw h. \_\_\_\_\_ arrive 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:

Senility  
Chronic Hypertension  
Chronic Nephritis  
 Other contributory causes of importance:  
Hypertension with Nephritis  
Chronic

Date of onset

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 B Growe \_\_\_\_\_, M. D.  
 (Address) 306 E 12th

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.

ST. JOSEPH COUNTY

S-15329