

REC'D APR 17 1936

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

9395
Do not use this space.

1001

Registered No. 1001

1. PLACE OF DEATH

(a) County Jackson 2 Registration District No. 399
(b) Township Kaw Primary Registration District No. 1002
(c) City Kansas City 1 (d) Street No. 220 West 54 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

255 Sarah Dismann
(a) Residence, No. 220 West 54th St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Benjamin Dismann
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Don't know
7. AGE YEARS 74 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at Home
9. Industry or business in which work was done, as 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) New York City, New York
FATHER 13. NAME Manuel Rosensteil
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
MOTHER 15. MAIDEN NAME Don't know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
17. INFORMANT (ADDRESS) Butler Dismann, 220 W 54th St.
18. BURIAL, CREMATION, OR REMOVAL PLACE Rose Hill DATE 3/7/1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Carroll Davidson, 3024 Front
Mo. 39 M. M. Brown
20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 6, 1939
22. I HEREBY CERTIFY, That I attended deceased from Sept 1938, to March 5, 1939
I last saw h. in alive on March 5, 1939. Death is said to have occurred on the date stated above, at 1:30 p.m.
The principal cause of death and related causes of importance were as follows:
arterio-sclerosis
Cerebral thrombosis,
multiple
Date of onset 5 yrs
3 mo.
Other contributory causes of importance:
Name of operation _____ 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 of deceased? No
If so, specify _____
(Signed) H. S. Selander, M. D.
(Address) 1405 Bryant Bldg.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.