

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

REC'D APR 11 1939

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

10167  
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85  
(b) Township Washington Primary Registration District No. 1001 Registered No. 325  
(c) City St Joseph (d) Street No. Mo. Meth. Hospital 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

(a) Residence, No. 809 S. 11th. 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 M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 29, 1905

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
33 6 27

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
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) UNKNOWN RUSSIA

FATHER 13. NAME H. B. Fishman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN RUSSIA

MOTHER 15. MAIDEN NAME UNKNOWN

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

17. INFORMANT (ADDRESS) Mr. H. B. Fishman  
809 S. 11th. St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Jersey City, N.J. DATE MAR. 27th. 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) FLEEMAN AND SON INC.  
1946 Cahoon St. Joseph, Mo.

20. FILED MAR 27 1939 H. McCallbush  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 26 1939

22. I HEREBY CERTIFY, That I attended deceased from March 25, 1939, to March 26, 1939  
I last saw her alive on March 26, 1939. Death is said to have occurred on the date stated above, at 4:30 P.M.  
The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis Date of onset 1930

Other contributory causes of importance: 1/2

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis clinical 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) V. H. Sapstein, M. D.  
(Address) 2107 Franklin St. Joseph, Mo.

**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 *John E. Rupp*.....

Licensed Embalmer No. *5986*.....

P. O. Address. *St. Joseph*.....

**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.**