

REC'D JUN 15 1939

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

Do not use this space.

18851

1. PLACE OF DEATH
County Jackson Registration District No. 403
Township Blue Springs Primary Registration District No. 5557
City Kansas City Municipal Tuberculosis Hosp. St. _____ Ward _____
2. FULL NAME Grodsman, Mrs. Pearl
(a) Residence, No. 801 East Armour St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 5 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 White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
45 8 20

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 _____
OCCUPATION none

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

13. NAME Adam Morris

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

15. MAIDEN NAME Ullie May George

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

17. INFORMANT (ADDRESS) Sister: Mrs. Margaret Mann

18. BURIAL, CREMATION, OR REMOVAL PLACE W. M. Crowe Co. DATE 5-24-39

19. UNDERTAKER (ADDRESS) W. M. Crowe

20. FILED 5-23-39 Registrar W. M. Crowe

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 23, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 9, 1937, to May 23, 1939
Last saw her alive on May 23, 1939 Death is said to have occurred on the date stated above, at 9:55 A.M.

The principal cause of death and related causes of importance were as follows:

PULMONARY TUBERCULOSIS Date of onset 1929
TUBERCULOUS PERITONITIS 1932

Other contributory causes of importance: 23'

Name of operation _____ Date of _____
What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

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 _____
W. M. Crowe, M. D.
Kansas City Mo

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

18851-39
 State File No. _____
 Registrar's No. 3208

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME *Mrs. Pearl Grossman*
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____
 4. Sex _____ 5. Color or race _____
 6. (a) Single, widowed, married, divorced _____
 5. (b) Name of husband or wife _____
 6. (c) Age of husband, or wife, if alive _____ year _____
 7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____
 If less than one day _____ hr. _____ min.
 9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 10. Usual occupation _____
 Industry or business _____
 12. Name _____
 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

(a) Informant _____
 (b) Address _____
 (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____
 (a) Signature of funeral director _____
 (b) Address _____
 (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

19. MEDICAL CERTIFICATION
 20. DATE OF DEATH _____ month _____ day _____
 year _____ hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
 that I last saw him _____ alive on _____ 19 _____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____
 (23)
 Jwd Jeff City
 8-14-40

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 _____ (Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

18857
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 1103
(b) Township Brookling Primary Registration District No. 5557
(c) City (d) Street No. 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

Mrs Pearl Grossman
(a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 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) Sept. 3 - 1894

7. AGE YEARS 45 MONTHS 8 DAYS 20 If LESS than 1 day, hrs. or min.

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Bourbon, Mo. DATE May 24, 1939

19. FUNERAL DIRECTOR (ADDRESS) Rose & Henderson
15th Jackson St. S.E. Mo.

20. FILED 5-23 1939 D. H. Buehlingham
Mrs Pearl Grossman Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-23 1939

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) H. A. Buehlingham, M. D.

(Address) Kansas City Mo.

SUPPLEMENTARY