

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.

RECD AUG 11 1939

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

25033
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 85
 (b) Township St Joseph Primary Registration District No. 1001 Registered No. 693
 (c) City St Joseph (d) Street No. Mo. Method St Hospital St. 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. 1 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME CHAS. LEVY
 (a) Residence, No. 100 St. King City Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 7, 1851

7. AGE YEARS 78 MONTHS 4 DAYS 0 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. clothing merchant
 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) July 8, 1939 11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Spring Hill Mo., Mo., U.S.A.

FATHER 13. NAME Samuel Levy
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alsace Lorraine Germany

MOTHER 15. MAIDEN NAME Johannah Juda
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Prussia Germany

17. INFORMANT (ADDRESS) Leon Mayer King City Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Adath Joseph Cem. July 9th, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Heaton B. Galt, 7 Brownwood 319 So 10th St Joseph

20. FILED 7/10 1939 H. M. Stelchak Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 7, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 7, 1939 to July 8, 1939
 I last saw him alive on July 7, 1939. Death is said to have occurred on the date stated above, at 11:40 P.M.
 The principal cause of death and related causes of importance were as follows:
arterial obstruction Date of onset 4/6

Other contributory causes of importance:
cardiomegaly of color

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 no 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 H. H. Walker M. D.
 (Signed) _____ (Address) 301 W. P. 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, 7/7/39

or by K

Registered Apprentice No., working under my personal supervision.

Signed W E Summerfield

Licensed Embalmer No. 3007

P. O. Address 379 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.