

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.

JAN 13 1940
Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Menahel Hosp 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 days
(Specify whether
In this community approx 75 years
years, months or days) 95

3. (a) PRINT FULL NAME Lickovitz, Mrs. Ethel
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex fe 5. Color or race w 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
approx 70 hr. min.

9. Birthplace Russia 7
(City, town, or county) (State or foreign country)

10. Usual occupation none 7

11. Industry or business _____

MOTHER FATHER { 12. Name Marie Strahok 9

13. Birthplace Russia (City, town, or county) (State or foreign country)

14. Maiden name eta unknown

15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Marie Brown

(b) Address 2732 Harrison

17. (a) Burial (b) Date thereof 12-3-39
(Burial, cremation, or removal) Blue Ridge (Month) (Day) (Year)
(c) Place: burial or cremation Central Cemetery

18. (a) Signature of funeral director H. J. ...

(b) Address NE. 2nd

19. (a) Dec. 3, 1939 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2732 Harrison
(If rural, give location)
(e) If foreign born, how long in U. S. A.? approx 25 years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 2
year 1939 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to Dec 2, 1939
and that I last saw her alive on Dec 2, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatosis Duration 2-3 mo
Carcinoma of stomach?
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Peritoneal
Of operations metastases
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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? _____

While at work? 1 (Specify type of place) (e) Means of injury _____

28. Signature L. H. Schaefer (M. D. or other) _____
Address 1405 Bryant Bldg Date signed 12/3/39

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.

Did not Embalm.

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.