

0 FEB 26 1940

399

Primary Registration District No. **1002**

Registrar's No. **285**

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:
Menorah Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **74 days**
(Specify whether years, months or days)
 In this community **35 years**

3. (a) PRINT FULL NAME **Hannah Brucker**

3. (b) If veteran, name war No. **No.**
 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **widowed**

6. (b) Name of husband or wife **unknown**
 6. (c) Age of husband or wife if alive **18 7 0** years

7. Birth date of deceased **July 15 18 7 0**
(Month) (Day) (Year)

8. AGE: Years **69** Months **6** Days **5**
 If less than one day hr. min.

9. Birthplace **Hungary**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business

12. Name **Morris Friedman**

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

14. Maiden name **Dora Klein**

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

16. (a) Informant's own signature **Mary Newman**
 (b) Address **Tulsa, Oklahoma**

17. (a) **Burial** (b) Date thereof **1-22-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Carmel**

18. (a) Signature of funeral director **J. P. Louis Funeral Home**
Kansas City, Mo.
 (b) Address

19. (a) **Jan. 23, 1940** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2850 Troost**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. **39 yrs** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **20**
 year **1940** hour minute M.

21. I hereby certify that I attended the deceased from **Nov. 10-39**
 to **Jan. 20 - 1940**

that I last saw her alive on **Jan. 20 - 1940**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **Hypertension for several years**

Due to **fracture of left hip**

Other conditions **short 6 weeks ago**

Major findings of operations **no.**

Of autopsy **no.**

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 (Specify type of place) (Means of injury)

23. Signature **Joseph H. Newman** (M. D. or other)
 Address **3201 Acacia Rd.** Date signed **Jan 21 - 40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39 I x1951

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.

PHYSICIAN
 Underline the cause to which death should be charged statistically

19412
Dr. [unclear]
[unclear]

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 Bert Legan

Licensed Embalmer No. 3939

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 1300
Registrar's No. 288

Registration District No. 399

Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C.
(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 _____
(Specify whether _____)
In this community _____
years, months or days

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.

3. (a) PRINT FULL NAME Hannah Buckner
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 6 5 hr. min.

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

10. Usual occupation _____

11. 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)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof: (Month) (Day) (Year)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 1/22/40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 20
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 Cerebral hemorrhage
Hypertension for several years
fracture of left hip about 6 weeks ago
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 1860
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Acc
(b) Date of occurrence Dec 6 1940
(c) Where did injury occur? Kansas City, Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature Joseph H. Freeman M.D. fall
Address 728 Argyle Bldg signed _____
K.C. Mo

SUPPLEMENTARY

