

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.

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:
814 Independence Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 28 Years (Specify whether years, months or days)
In this community 28 Years

3. (a) PRINT FULL NAME Henry Feinberg

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 16 1911
(Month) (Day) (Year)

8. AGE: Years 29 Months - Days 23 If less than one day hr. _____ min. _____

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

10. Usual occupation Clerk

11. Industry or business _____

12. Name Louis Feinberg

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

14. Maiden name Fannie Goldstein

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

16. (a) Informant's own signature Louis Feinberg

(b) Address 814 Independence Ave.

17. (a) Burial (b) Date thereof 2-9-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheffield

18. (a) Signature of funeral director J. P. Louis Funeral Home

(b) Address 3400 Woodland, K. C. Mo.

19. (a) Feb. 8, 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. 814 Independence Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 8th
year 1940 hour _____ minute 7:30 M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Shot wound of head

Due to 16'

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 28-40

(b) Date of occurrence _____

(c) Where did injury occur? J. C. Mo (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) _____

23. Signature Walter M. Sullivan or other) _____

Address K. C. Mo Date signed _____

PHYSICIAN
Underline the cause to which death should be charged statistically

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 _____

_____ *Myself* _____, Registered Apprentice No. _____
working under my personal supervision.

Signed *Bert Legan* _____

Licensed Embalmer No. *3979* _____

P. O. Address *H.C. Ms.* _____

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.