S. No. 2
—11-10-39
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9592

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 1026

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3533 Prospect (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 Mo (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 3533 Prospect (If rural, give location)
(e) If foreign born, how long in U. S. A.? approx 40 years.

3. (a) PRINT FULL NAME Rebecca Slabotsky #13
8. (b) If veteran, name war ____ (c) Social Security No. ____
Rebecca Slabotsky

4. Sex f | 5. Color or race W | 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Israel | 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased unknown (Month) (Day) (Year)

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

9. Birthplace Rumania (City, town, or county) (State or foreign country)
10. Usual occupation ____
11. Industry or business Housewife
FATHER 12. Name unknown
13. Birthplace unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant Israel Slabotsky
(b) Address 3533 Prospect
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-40 (Month) (Day) (Year)
(c) Place: burial or cremation Schofield Cemetery
18. (a) Signature of funeral director H. Higerman & Sons
(b) Address K.C. Mo
19. (a) Mch 5 1940 (Date received by local registrar) (b) M. R. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4th year 1940 hour 3--A M. minute ____ M.

21. I hereby certify that I attended the deceased from October 10, 1939 to Jan. 26, 1940 that I last saw her alive on Jan. 26, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Valvular Chronic cardiac valular disease with decompensation and hypertension	6 mo.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature [illegible] M.D. (or other)
Address 728 Argyle Bldg Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 J. K. Rigsman

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.