

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1113

APR 28 1940

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:
5424 Paseo
(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) 50 yrs

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. 5424 Paseo
(If rural, give location)
(e) If foreign born, how long in U. S. A? 50 years.

3. (a) PRINT FULL NAME Henry Lustig - 237

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10th
year 1940 hour 4⁰⁰ minute 4 M.

21. I hereby certify that I attended the deceased from Oct 1st
1939 to Mar. 10th 1940
that I last saw him alive on March 9th 1940
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Wh
6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
Anna Lustig alive 66 years
7. Birth date of deceased February 20 - 1865
(Month) (Day) (Year)

Immediate cause of death: Broncho-Pneumonia Duration 7 days
Due to Hemiplegia Hypertension 7 years

8. AGE: Years 75 Months 0 Days 19 If less than one day
hr. _____ min.

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

10. Usual occupation Retired Merchant

11. Industry or business Dry goods

12. Name M. Lustig

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

14. Maiden name Went brown

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

16. (a) Informant's own signature Mortimer Lustig

(b) Address 5424 Paseo

17. (a) Burial (b) Date thereof 3/12/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Carroll Warden

(b) Address 3024 Woodlawn

19. (a) Mch 11, 1940 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

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) _____

(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 Dr. Joseph Szelowski (M. D. or other) M.D.

Address 1219 North 13th Date signed 3-11-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

109W

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

Signed E. P. Casey
Licensed Embalmer No. 1972
P. O. Address 3024 Proast

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

State File No. 9679
Registrar's No. 1113

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town R.C.
(If outside city or town limits, write "RURAL" and name of township)
(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.
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Henry Lustig

3. (b) If veteran, name war. 3. (c) Social Security No.

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

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 year, 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) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) March 11, 1940 (b) M. M. Crowe (Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar. day 10 year 1940 hour 4:0 minute 0 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 from the pneumonia
not emphysema
caused by cerebral hemorrhage
Due to Hypertension 80's!
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?

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

23. Signature Joseph Gatalone (M. D. or other) Address. Date signed.

SUPPLEMENTARY

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

MOTHER FATHER

1940
S-9679