

MAY 15 1940

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1598

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:
Memorial Hosp
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 60 Years
(Specify whether years, months or days)
 In this community _____

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. 1616 Linwood Blvd
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? 60 years.

3. (a) PRINT FULL NAME Morris Bigus

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

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

6. (b) Name of husband or wife Mollie 6. (c) Age of husband or wife if alive 1870 years

7. Birth date of deceased OCT 15 1867
(Month) (Day) (Year)

8. AGE: Years 69 Months 72 Days 6 28
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired 7

11. Industry or business Merchant

12. Name Isaac Bigus 7

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

14. Maiden name Ella Linko

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

16. (a) Informant Henry Hakan

(b) Address K. C. Mo.

17. (a) Burial (b) Date thereof 4-15-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Mausoleum

18. (a) Signature of funeral director L. P. Lewis

(b) Address 3400 Woodland

19. (a) April 15, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13
 year 1940 hour 11 minute 15 P. M.

21. I hereby certify that I attended the deceased from March 6
 1940, to April 13 1940

that I last saw him alive on April 13 1940
 and that death occurred on the date and hour stated above. 11. 15

Immediate cause of death _____

Pulmonary Infarction Pt. Cong. - Secondary cardiac failure

Due to occurred post-operatively from embolus

Due to Capillary thrombosis before death

Other conditions Some acute disease
(Include pregnancy within 3 months of death)

Major findings: Prostatic hypertrophy

Of operations _____
 Of autopsy 139

Duration

PHYSICIAN

Underlines 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? _____ (a) Means of injury 1

23. Signature Lucy S. Miller (M. D. or other) _____

Address 1137 Garwood Bldg Date signed April 15/40

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

MOTHER FATHER

M. J. ...

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.....

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.

1-0-39
17-39
X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13886
Registrar's No. 1598

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Memorial Hospital
(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 _____

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

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 alive _____ years

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 12
year 1940 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.

8. AGE: Years 72 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4/12/40 (b) M. M. Crow
(Date received by registrar) (Registrar's signature)

Impediment cause of death: Pulmonary infarction rt lung secondary - Cardiac failure

Due to P.O. from supra pubic Custody

Due to Heart - failure, delayed myocardial damage - acute infarction terminal failure due to

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

Major findings: terminal infarct

Of operations _____

Of autopsy _____

Duration _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

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.....

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.