

S. No. 2  
-11-10-39  
5-17-39  
X21492

JUN 17 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1859

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

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:  
2850 Troost  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community About 23 Years  
years, months or days)

3. (a) PRINT FULL NAME Ida Minovitz 513

3. (b) If veteran, name war 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 Fred Minovitz  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

8. AGE: Years 70 Months - Days -  
If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Home duties

11. Industry or business \_\_\_\_\_

12. Name Abe

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

14. Maiden name Elka

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

16. (a) Informant Mrs. Bessie Block

(b) Address 5419 Michigan, K. C. Mo.

17. (a) Burial (b) Date thereof 5-3-1940  
(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

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

19. (a) May 31, 1940 (b) M. M. Grove  
(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.? About 23 Years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2  
year 1940 hour 4 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 1 mo.  
\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;

that I last saw her alive on May 2  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary  
Thrombosis  
cardiac Astma

Due to \_\_\_\_\_

Due to Chronic - Chronic  
Nephritis

Other conditions 131  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of work) (Cause of injury)

23. Signature Joseph H. [unclear] (M. D. or other)

Address 325 [unclear]

Duration

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.....

....., Registered Apprentice No.....

working under my personal supervision.....

Signed.....

*Bert Logan*

Licensed Embalmer No. *3979*

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.**