

FILED JUN 17 1940

State File No. _____

1986

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson 2

(b) City or town Kansas City

(c) Name of hospital or institution: 2701 Linwood Blvd
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 48 years (Specify whether years, months or days)

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. 209 East 65th
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME SAMUEL DRETZER

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male 5. Color or race wh

6. (a) Single, widowed, married, divorced widow

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

7. Birth date of deceased Nov 4, 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68 6 8 hr. _____ min.

9. Birthplace New York City 1
(City, town, or county) (State or foreign country)

10. Usual occupation Retired tailor 7

11. Industry or business _____

MOTHER FATHER

12. Name Moses Dretzer 7

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

14. Maiden name Dora

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

16. (a) Informant David Dretzer

(b) Address 209 E 65th

17. (a) Burial (b) Date thereof 5/14/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill

18. (a) Signature of funeral director Carroll Davison

(b) Address 2024 Troost

19. (a) May 13, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from June 10, 1939 to May 12, 1940
and that death occurred on the date and hour stated above

Immediate cause of death Ch. Nephritic failure

Duration _____

Due to _____ 121

Due to _____ 121

Other conditions Ch. Nephritis
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

23. Signature W. H. Brown M. D. or other _____
Address 209 E 65th Date signed 5-12

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 C. P. Casey

Licensed Embalmer No. 1972

P. O. Address 3024 Troost

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.