No. 2
4-13-40
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31033

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 3596

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: 3223 Michigan (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 2 (Specify whether years, months or days)

In this community: Unknown

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.: 3223 Michigan (If rural, give location)

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

3. (a) PRINT FULL NAME: Etta Frank

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Fe

5. Color or race: Wh

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Morris

6. (c) Age of husband or wife if alive: -- years

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

8. AGE: Years 72 | Months -- | Days -- | If less than one day ____ hr. ____ min.

9. Birthplace: Russia (City, town, or county) (State or foreign country): 7

10. Usual occupation: Housewife: 4

11. Industry or business: 9

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Unknown (City, town, or county) (State or foreign country): 1

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Leon Joseph

(b) Address: 807 E. 15th

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 15, 40 (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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept. day: 14 year: 1940 hour: 3:30 minute: P. M.

21. I hereby certify that I attended the deceased from 1937, 19__, to Sept. 14, 1940 that I last saw her alive on Sept. 14, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardiac Decompensation	1 week
Due to: Hypertensive Heart Disease	many years
Due to:	
Other conditions (Include pregnancy within 3 months of death): Chronic Bronchial Asthma	many years
Emphysema 95B	many years

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

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23. Signature: Jack W. Wolf (M. D. or other) M.D.

Address: 620 Argyle Bldg. Date signed: 9-14-40

(Licensed Embalmer's Statement on Reverse Side) K.C. Mo.

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.