

2-40  
-39  
23159

DEPARTMENT OF COMMERCE MISSOURI STATE BOARD OF HEALTH  
BUREAU OF THE CENSUS STANDARD CERTIFICATE OF DEATH

State File No. 31156  
3719  
Registrar's No.

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Manorah Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 Weeks  
(Specify whether years, months or days) 20 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Kansas (b) County Wyandotte  
(c) City or town Kansas City, Kansas  
(If outside city or town limits, write "RURAL")  
(d) Street No. 924 Northrup St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 20 years.

3. (a) PRINT FULL NAME Sol Schachter  
3. (b) If veteran, name war No 3. (c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 28/24/40 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 10/18 - 28/24/40 19\_\_\_\_  
that I last saw him alive on 28/23/40 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Emley 6. (c) Age of husband or wife if alive 45 years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

Immediate cause of death Weakness of heart Duration \_\_\_\_\_  
Due to The adenitis of the pericardium.

8. AGE: Years 48 Months -- Days -- If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

9. Birthplace Austra Austra  
(City, town, or county) (State or foreign country)  
10. Usual occupation Merchant  
11. Industry or business "

Other conditions (Include pregnancy within 3 months of death) 25  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER { 12. Name Alter  
13. Birthplace Austra Austra  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Austra Austra  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Noa Schachter  
(b) Address 726 St. Paul  
17. (a) Burial (b) Date thereof Sept. 24, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sheffield Cem

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? \_\_\_\_\_

18. (a) Signature of funeral director Louis Funeral Home  
(b) Address 3400 Woodland K.C. Mo.  
9-24-40  
(Date received local registrar) (b) m. m. browe  
(Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature Dr. Robert Unimann (M.D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

D. H. ~~Johnson~~

Bryant 1314

Sta 8495-

**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 the above constitutes grounds for revocation of license.)**

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