

NOV 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1002

State File No. **34598**
Registrar's No. **4114**

Registration District No. _____

Primary Registration District No. _____

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: McNarah
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 18 Days 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. 5039 Wyandotte (If rural, give location)
(e) If foreign born, how long in U. S. A.? 35 yrs years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 27 day Oct
year 1940 hour _____ minute 12:50 P. M.

21. I hereby certify that I attended the deceased from Oct 19 1940, to Oct 27 1940
that I last saw him alive on Oct 27 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of left kidney 51
Due to _____ 7 mos.
Due to _____

Other conditions: Myocardial fibrosis
Diabetes mellitus
Major findings: Arteriosclerosis
Of operations _____
Of autopsy Yes

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

3. (a) PRINT FULL NAME Samuel Bograd

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race W. Y. 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Not Known
(Month) (Day) (Year)

8. AGE: Years 60 Months - Days - If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Cabinet Maker

12. Name Not Known

13. Birthplace Not Known
(City, town, or county) (State or foreign country)

14. Maiden name Not Known

15. Birthplace Not Known
(City, town, or county) (State or foreign country)

16. (a) Informant Abe Bograd
(b) Address K. C. Mo.

17. (a) Burial (b) Date thereof 10-28-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Carmel

18. (a) Signature of funeral director J. P. Lewis
(b) Address K. C. Mo.

19. (a) 10-28-40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury
23. Signature J. Morris M. D. or other _____
*Address 470 Prof. Bldg Date signed 10-28-40

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.