

12-40  
7-39  
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DEC 16 1940 85  
Registration District No.

Primary Registration District No. 1001

State File No.

Registrar's No. 1289

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(c) Name of hospital or institution: St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 33 years  
In this community 33 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 532 N. 24th.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME: MAX L. RESNIK

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

4. Sex male  
5. Color or race white  
6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife: Mollie Resnik  
6. (c) Age of husband or wife if alive years 1876

7. Birth date of deceased: Jan. 15th. 1876  
(Month) (Day) (Year)

8. AGE: Years 64 Months 10 Days 24  
If less than one day hr. min.

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

10. Usual occupation: Retail Furniture Dealer

11. Industry or business: Furniture Store

12. Name: Tubie Resnik

13. Birthplace: unknown Russia  
(City, town, or county) (State or foreign country)

14. Maiden name: Unknown

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

16. (a) Informant: Edith Resnik

(b) Address: 532 N. 24th. St. Joseph, Mo.

17. (a) Burial (b) Date thereof: 12-10-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Shaare Sholem Cemetery

18. (a) Signature of funeral director: FLEEMAN & SON INC.

(b) Address: St. Joseph, Mo.

19. (a) Dec 10 - 1940 (b) [Signature] (c) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9th.  
year 1940 hour 11 minute 40 P.M.

I certify that I attended the deceased from week 10, 1940, to see 9, 1940  
that I last saw him alive on see 9, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: carcinoma stomach  
Duration: ?

Due to: 40

Other conditions: active alcoholism, art. skin head disease  
(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 place) (c) Means of injury

23. Signature: Dr. Johnson (M. D. or other) [Signature]  
Address: Kirk Bldg. St. Joseph, Mo. Date signed: 12-10-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

JUL 22 1942

**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.....  
.....  
working under my personal supervision.

Registered Apprentice No.....

*Not Embalmed*

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, fact should be so stated above.**