

Registration District No. **399**

Primary Registration District No. **1002**

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: **K.C. General Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12 days**
(Specify whether
In this community **Unknown**
years, months or days)

3. (a) PRINT FULL NAME **Frank Mandel**

8. (b) If veteran, name war **No record** 3. (c) Social Security No. **NO**

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **July 7th 1883**
(Month) (Day) (Year)

8. AGE: Years **57** Months **4** Days **11** If less than one day hr. min.

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

10. Usual occupation **Salesman**

11. Industry or business _____

12. Name **Adam Mandel**

13. Birthplace **Poland**
(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 **Record clerk**

(b) Address **K.C. Gen. Hospital**

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

(c) Place: burial or cremation **Kirksville, Missouri**

18. (a) Signature of funeral director **Weilert Funeral Home**

(b) Address **2332 Monitor Place; K. C. MO**

19. (a) **12-10-40** (b) **M. M. Crowe**
(Date of local registrar) (Registrar's signature)

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. **Helping Hand**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **18th**
year **1940** hour **12 P.** minute _____ M.

21. I hereby certify that I attended the deceased from **11-6-40**, 19____, to **11-18-40**, 19____;
that I last saw him alive on **11-18-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart disease, arteriosclerotic, with coronary occlusion; infarction of heart**

Due to _____
Due to **95B**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy **None**

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) (e) Means of injury **1**

23. Signature **Dr. R. Shaw** (M. D. or other)
Address **Med. Dir. K.C. Gen. Hospital** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Blaine E. U. Weiland

Licensed Embalmer No.

4075

P. O. Address

2332 Monitor, Ill.

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.