

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City 2  
(c) Name of hospital or institution:  
(If outside city or town limits, write "RURAL" and name of township)  
3704 St. Johns ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 22 Yrs  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME SIMON RABIN  
3. (b) If veteran, name war NO  
3. (c) Social Security No. NONE

4. Sex Male 5. Color or race wh  
6. (a) Single, widowed, married divorced Married  
6. (b) Name of husband or wife: Rennie Rabin 6. (c) Age of husband or wife if alive 19 years  
7. Birth date of deceased: August 8 1868 (Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 15 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

12. Name Mendall Rabin

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

14. Maiden name Leah Unknown

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

16. (a) Informant Mrs. Fannie Rabin

(b) Address 3784 St. Johns ave

17. (a) Burial (b) Date thereof 12-24-40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director P. J. Lewis

(b) Address 3400 Woodland

19. (a) Dec. 23, 1940 (b) M. M. Crow (Date received 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. 3704 St. Johns ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec 22 1940 day 11:35 pm year 1940 hour 11 minute 35 P.M.

21. I hereby certify that I attended the deceased from Nov. 28, 1940 to Dec 22, 1940 that I last saw him alive on Dec 22, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Myocarditis Duration 10 yrs

Due to Chr. Myocarditis  
Due to Cerebral Hemorrhage 11 yrs

Other conditions Cerebral Hemorrhage (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: Of operations Of autopsy 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?  
While at work? (Specify type of place) (e) Means of injury

23. Signature [Signature] (M. D. or other) Address 905 N. 7th St., P.C.K. Date signed 12/23/40

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

MOTHER FATHER

**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 *P. L. Lewis*  
Licensed Embalmer No. *3110*  
P. O. Address *H. C. ...*

**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.**