

Registration District No. **88**

Primary Registration District No. **4412**

82

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

1. PLACE OF DEATH:

(a) County Pike
 (b) City or town Frankford
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 30 Years years, months or days) 2

8. (a) PRINT FULL NAME Simon Kaifman

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eva Uderwitz Kaifman 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Sept 13 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>3</u>	<u>14</u>	hr. _____ min.

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

10. Usual occupation Merchant

11. Industry or business Drygoods

12. Name Simon Kaifman

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 Anna K. Anderson
 (b) Address Frankford Missouri

17. (a) Burial (b) Date thereof Dec 29 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Louisiana Missouri

18. (a) Signature of funeral director Philip Flon

(b) Address Frankford Missouri

19. (a) Dec-29 (b) Mattie Unsell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike
 (c) City or town Frankford
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A. 46 Years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 27
 year 1949 hour 9 minute 45 P. M.

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

Immediate cause of death Cerebral Hemorrhage
 Duration _____

Due to _____
 Due to _____

Other conditions g. p. n.
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN

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 W. Anderson (M. D. or other) _____

Address Frankford, Mo Date signed 12/27/40

#5

RECEIVED

District Health Officer No. 10

District File Number 1-41-2

Date Filed JAN 7 1941

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 Israel Fields Theggers

Licensed Embalmer No. 4093

P. O. Address Franklin Theggers

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.