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FILED MAY 16 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 13341

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1322

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: ST. JOSEPH HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 DAYS  
(Specify whether years, months or days)

In this community ABOUT 30 YEARS

3. (a) PRENT FULL NAME ESTHER EISMAN

3. (b) If veteran, name was NO

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife SAMUEL EISMAN

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased OCTOBER 1 1893  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>6</u>	<u>1</u>	hr. _____ min. _____

9. Birthplace POLAND 4  
(City, town, or county) (State or foreign country)

10. Usual occupation HOME DUTIES

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN 4  
(City, town, or county) (State or foreign country)

16. (a) Informant HARRY EISMAN

(b) Address 2113 E. 59TH KC. MO

17. (a) BURIAL (b) Date thereof 4-5-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BLUE RIDGE

18. (a) Signature of funeral director J. PLOVIS FUNERAL HOME

(b) Address 3400 WOODLAND K.C. MO

19. (a) Apr. 4, 1941 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

(c) City or town KANSAS CITY 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 205 GARFIELD 8  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ABOUT 030 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 3  
year 1941 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from 7-22-40  
4-2, 1941, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on 4-2, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration  
Hypertension & Arteriosclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (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 P. J. De Marco MD (M. D. or other) \_\_\_\_\_

Address 1408 Mulberry Bldg. Date signed \_\_\_\_\_

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

Dr. P. De Maria  
Welding 12/24/49

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.....

MYSELF

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Bert Legan

Licensed Embalmer No.....

3979

P. O. Address.....

Kansas City

-Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. **1322**

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Esther Eisman

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female Color or race White 5. Color or race.....  
 6. (a) Single, widowed, married, divorced.....  
 6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if  
 alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
57..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....  
 { 13. Birthplace..... (City, town, or county) (State or foreign country)  
 { 14. Maiden name.....  
 { 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) May 10/41 (b) M. M. Crowe  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
 (c) City or town..... (If outside city or town limits write "RURAL")  
 (d) Street No. 205 Garfield (If rural, give location)  
 (e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2nd  
 year 1941 hour..... minute..... M.

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

Immediate cause of death.....  
Cerebral Hemorrhage

Due to Hypertensive and cardiac failure  
Hypertensive Heart Disease

Due to.....  
 Other conditions..... (Include pregnancy within 3 months of death) 93 D

Major findings:  
 Of operations.....  
 Of autopsy.....

Duration

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) (c) Means of injury.....

23. Signature..... (M. D. or other).....  
 Address..... Date signed.....

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

SUPPLEMENTARY

S-1334 1941