

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: 714 Virginia  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 21 YEARS 1 years, months or days

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. 714 Virginia  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 21 yrs

3. (a) PRINT FULL NAME Ruth Indin

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

4. Sex Fe 5. Color or race Wh  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Simon  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan 10 1899  
(Month) (Day) (Year)

8. AGE: Years 42 Months 7 Days 5  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House Wife

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

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

16. (a) Informant Simon Indin  
(b) Address 714 Virginia  
17. (a) Mr Carmel (b) Date thereof 8-15 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mr Carmel

18. (a) Signature of funeral director J. P. Louis Funeral Home  
(b) Address 3400 Woodland Ave  
19. (a) 91741 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15  
year \_\_\_\_\_ hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from 6-30 1938 to 8-15 1941  
that I last saw h \_\_\_\_\_ alive on 8-12 \_\_\_\_\_ 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Cancer of maxillary sinus with spread to  
Due to infection of skull  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(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?

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature Donald D. Danforth (M.D. or other) \_\_\_\_\_  
Address 440 Angell Bldg Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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, Mo.*

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

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