

DEC 22 1941 399
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:
415 Benton Blvd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
In this community 45 Years

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. 415 Benton Blvd.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 14
year 1941 hour 12 minute Noon M.
21. I hereby certify that I attended the deceased from
1/9/35, 19____, to 11/7/41, 19____;
that I last saw him alive on 11/7/41, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension and heart failure
Duration _____

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 J. H. Decker (M. D. or other) _____
Address 1034 Rialto Building Date signed _____

3. (a) PRINT Mr. Kaliel S. Zammar
FULL NAME

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

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

6. (b) Name of husband or wife Maude Zammar
6. (c) Age of husband or wife if alive 55? years

7. Birth date of deceased September 14 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 2 0 _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Police Force

12. Name Slyman Zammar

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

14. Maiden name Lulu Annis

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

16. (a) Informant Mrs. Maude Zammar

(b) Address 415 Benton Blvd.

17. (a) Burial (b) Date thereof Nov. 17, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Mary's Cemetery

18. (a) Signature of funeral director D. F. Newcomer
(b) Address 1401 Brush Creek Blvd.

19. (a) 11-15-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

Green 1007
4-5-53

STATE OF MISSOURI
DEPARTMENT OF HEALTH

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..... *Ernie M. Colburn*.....

Licensed Embalmer No. *3506*.....

P. O. Address..... *KC Mo*.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **4244**

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:
415 Benton Blvd.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Kaliel S. Zammar**

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

4. Sex 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
60 hr. 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) **Dec 31 1941** **M. M. Corome** (Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV** day **14**
year **1941** hour minute M.

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

Immediate cause of death

Hypertension and heart failure
Cardiac hypertrophy

Due to **myocardial degeneration**

Due to **Essential hypertension**

Other conditions (Include pregnancy within 3 months of death) **93.5**

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) (e) Means of injury

23. Signature **M. M. Corome** (M. D. or other)

Address **R.F. no** Date signed **12/23/41**

SUPPLEMENTARY

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

S-37449

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.....

Licensed Embalmer No.....

P. O. Address.....

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.