

HLD MAR 10 1947 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

828

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: 719 Garfield  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 28 years  
(Specify whether 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. 719 Garfield  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ben Deleve

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27  
year 1947 hour 9 minute \_\_\_\_\_ M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Rose Deleve

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

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

21. I hereby certify that I attended the deceased from 1938 to Feb, 1947  
that I last saw h.i.m. alive on Feb 25, 1947  
and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Peritonitis

Due to Carcinoma of rectum

Due to 46 15

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace 10 Russia  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

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

12. Name Morton Deleve

13. Birthplace 10 Russia  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace 10 Russia  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Leon Deleve

(b) Address 4020 College K. C. Mo.

17. (a) Burial (b) Date thereof 3-1-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge

18. (a) Signature of funeral director J. P. Louis Funeral Home

(b) Address 3400 Woodland K. C. Mo.

19. (a) 3/1/42 (b) M. G. Crown  
(Date local registrar) (Registrar's signature)

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)

23. Signature Henry K. Cohen M.D. (M. D. or other) M.D.  
Address 318 Angelle Bldg Date signed 2-28-47

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

MOTHER FATHER

361

**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.....

*H.C. Mrs.*

**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.**