

FILED APR 25 1942

Registration District No. 399

Primary Registration District No. 1001

Registrar's No. 1294

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Menorah Hospital  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: In hospital or institution 2 Days (Specify whether  
In this community 2 ~~years~~ years (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 049  
(c) City or town Kansas City (If outside city or town limits, write "RURAL")  
(d) Street No. 4019 Tracy (If rural, give location)  
(e) Citizen of foreign country? Yes (Yes or No)  
If yes, name country Germany

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5th, 1942  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from April 3rd  
1942 to April 5th, 1942  
that I last saw her alive on April 5th, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Right Opturator Duration  
Hernia, Strangulated 3 1/2 Days

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

Other conditions Acute Intestinal Obstruction  
(Include pregnancy within 3 months of death)  
18 in. Terminal Ileum

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy Strangulated Hernia,  
Opturator

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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 C. J. Wyman (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 4-6-42

3. (a) PRINT FULL NAME Miss Line Schwarz

3. (b) If veteran, name war No 3. (c) Social Security No. 710

4. Sex F 5. Color or race W German 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Apr 14 1942  
(Month) (Day) (Year)

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

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

10. Usual occupation Home Duties

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

12. Name Jesais Schwarz

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

14. Maiden name Fannie Becker

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

16. (a) Informant Gerta Baruch

(b) Address Gerta B. K.C. Mo

17. (a) Burial (b) Date thereof 4-7-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. P. Louis Church (Home)

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

(b) Address \_\_\_\_\_

19. (a) 4-7-42 (b) H. M. Crowe  
(Date received local registrar) (Registrar's signature)

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

78  
3  
8

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**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.**