

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 19 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37396

State File No. _____
Registrar's No. **4608**

Registration District No. 149

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: _____
231 Ward Parkway
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 231 Ward Parkway
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph Marymont

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

4. Sex M 5. Color of race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cora S. Marymont 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased October 28 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>70</u>		<u>0</u>	<u>1</u>	hr. min.

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

10. Usual occupation Retired

11. Industry or business Merchant

12. Name Dont Know Poland

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

14. Maiden name Dont Know

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

16. (a) Informant Jules E. Kohn

(b) Address 321 Ward Parkway

17. (a) Cremation (b) Date thereof 10/31/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D. W. Newcomers

18. (a) Signature of funeral director Carroll-Davidson

(b) Address 3024 Troost

19. (a) 10-30-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29
year 1943 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from Feb 1 1943 to Oct 29 1943
that I last saw him alive on Oct 29 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coronary Failure

Due to Coronary Occlusion

Other conditions 940
(Include pregnancy within 3 months of death)

Duration
3 day
3 mo.

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? _____

23. Signature Reif M. Kohn (M. D. or other) MD

Address 630 Proj Bldg Date signed 10/29/43

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.