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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 17 1943

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 143

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Rural - Prairie in RD  
(c) Name of hospital or institution: Jackson County Home for aged  
(d) Length of stay: In hospital or institution 2 months  
In this community 21 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City, Mo.  
(d) Street No. 817 Monroe  
(e) Citizen of foreign country? Yes (Yes or No)  
If yes, name country RUSSIA

3. (a) PRINT FULL NAME Isaac M. Li'kowsk i

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

4. Sex M 5. Color or Race W 6. (a) Single, widowed, married, divorced Single

(b) Name of husband or wife (c) Age of husband or wife if alive years

7. Birth date of deceased No. 1890

8. AGE: Years 53 Months - Days - If less than one day hr. min.

9. Birthplace Katy, Basen Poland

10. Usual occupation Broker

11. Industry or business

12. Name Benj. M. Li'kowsk i

13. Birthplace RUSSIA

14. Maiden name NOT KNOWN

15. Birthplace NOT KNOWN

16. (a) Informant Rose Givshury (b) Address 817 Monroe St. C. Mo.

17. (a) BURIAL (b) Date thereof 11-11-43 (c) Place: burial or cremation Blue Ridge Cem

18. (a) Signature of funeral director J. P. Louis Funeral Home (b) Address K.C. Mo.

19. (a) Nov. 10, 1943 (b) J. H. Schick (c) J. H. Schick

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11 year 1943 hour 1:00 minute 9 M.  
21. I hereby certify that I attended the deceased from 9/11/43 to 11/8/43  
that I last saw him alive on 11/6 and that death occurred on the date and hour stated above.

Immediate cause of death de umbitus

Due to Encephalitis

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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature J. W. Green (M. D. or other) Address 118/43 Date signed 11/8/43

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

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

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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.....

*Richard Lewis*

Licensed Embalmer No. *2110*

P. O. Address *K.C. 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_ JAN  
Registrar's No. 147

Registration District No. 150 Primary Registration District No. 5572

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Rural Prairie Twp.  
(c) Name of hospital or institution:  
(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)

3. (a) PRINT FULL NAME Isaac Milkowaka  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased mm- (Month) (Day) (Year)

8. AGE: Years 53 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day, min. \_\_\_\_\_  
9. Birthplace Poland (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) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1933  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Metcephalitis lethargica epidemic in 1932  
Due to \_\_\_\_\_ time of onset.

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_  
PHYSICIAN 376  
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. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-42544