

FILED MAR 9 1944
1944

State File No. _____

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 972

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 Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
(Specify whether years, months or days) 35 yrs.

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. 3214 Chestnut
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph Bernstein
3. (b) If veteran name war none 3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH Month Feb day 27
year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Dec 14, 1944, to Feb 27, 1944
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race wh
6. (a) Single, widowed, married divorced _____
6. (b) Name of husband or wife Bessie 6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased July 15 1888
(Month) (Day) (Year)

Immediate cause of death Coronary thrombosis - Myocarditis - Uremia
Due to _____
Due to Chronic nephritis
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years 55 Months 7 Days 14
If less than one day hr. _____ min. _____
9. Birthplace Russia
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy 131/11
PHYSICIAN
Underline the cause to which death should be charged statistically.

10. Usual occupation merchant
11. Industry or business _____
12. Name Mayer Bernstein
13. Birthplace Russia
(City, town, or county) (State or foreign country)
14. Maiden name Sonia Eisenman
15. Birthplace Russia
(City, town, or county) (State or foreign country)

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 0

16. (a) Informant Sam Bernstein
(b) Address 3214 Chestnut
17. (a) Burial (b) Date thereof 3-2-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Blue Ridge Cem
18. (a) Signature of funeral director J. P. Houis Funeral Home
(b) Address 3400 Woodland
19. (a) 3-1-44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

23. Signature P. S. Sogler (M. D. or other) _____
Address 1405 Bryant Bldg Date signed Mar 1/44

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

MOTHER FATHER

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.....
[Handwritten Signature]

Licensed Embalmer No.....
310

P.O. Address.....
15-0-140

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 912

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:
Menorah Hospital
(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 Joseph Bernstein

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..... year.....

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

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

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

10. Usual occupation.....

11. Industry or business.....

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)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director..... (b) Address.....

19. (a) May 16 1944 (b) T. E. Brown
(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) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month Feb day 29
year 1944 hour..... minute..... M.

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

Immediate cause of death: Coronary Thrombosis

Due to Myocarditis

Due to Anemia - chronic hepatic

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

Major findings: Of operations.....

Of autopsy..... 1318

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 A. Saphar (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

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

MOTHER FATHER

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

5945