

FILED MAY 11 1944

Primary Registration District No. 1000

Registrar's No. 391

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 yrs 7 mo 19 da
(Specify whether
In this community yes 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 unknown
(If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Steve Dey Seff

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

4. Sex M, O 5. Color or race W 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife not known 6. (c) Age of husband or wife if alive not known years
7. Birth date of deceased. Not known (Month) (Day) (Year)

8. AGE: Years 49 Months ? Days ? If less than one day hr. min.

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

10. Usual occupation Not known

11. Industry or business

MOTHER FATHER { 12. Name Not known
13. Birthplace Not known (City, town, or county) (State or foreign country)
14. Maiden name Not known
15. Birthplace Not known (City, town, or county) (State or foreign country)

16. (a) Informant Hospital record

(b) Address St Joseph Mo

17. (a) Burial (b) Date thereof 4-4-44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation State Hosp # 2

18. (a) Signature of funeral director Blumson

(b) Address St Joseph Mo

19. (a) 4/3-44 (b) Ose Stegany (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 3 year 1944 hour 3-20 minute 9 M.

21. I hereby certify that I attended the deceased from 3-20 to 4-4 that I last saw him alive on 4-2 and that death occurred on the date and hour stated above.

Immediate cause of death Abscess Lung Lower R. Lobe

Due to
Due to

Other conditions Manic Depressive (Include pregnancy within 3 months of death)

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature Ose Stegany M.D. (M. D. Registrar) Address St Joseph Mo Date signed

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

STATEMENT BY LICENSED EMBALMER

not

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.....

Robert Lytle

Licensed Embalmer No.....

3308

P. O. Address.....

St Joseph, MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

State File No. may
Registrar's No. 391

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH: Buchanan
 (a) County Buchanan
 (b) City or town St. Joseph
 (If outside city or town limits, write "RURAL" and name of township)
 (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 _____ (Specify whether _____)
 years, months or days

3. (a) PRINT FULL NAME Steve Orsuff
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced un
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 49 Months _____ Days _____ If less than one day _____ min.

9. Birthplace Belgian
 (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)

(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1944 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____; _____ 19____;

that last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to Tuberculosis
 Due to _____

Other conditions manic depression
 (Include pregnancy within 3 months of death)

Major findings: 13 pl
 Of operations _____
 Of autopsy _____

Duration

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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature E. E. Salzer M.D. (M. D. or other)
 Address St. Joseph Mo Date signed _____

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

SUPPLEMENTARY

14148