

No. 2
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-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 23 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17178

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2030

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: A Menorah Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 da
(Specify whether years, months or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2850 Troost
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ben Schwartzstein

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

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased No Record
(Month) (Day) (Year)

8. AGE: Years 76 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business Merchant

12. Name No Record

13. Birthplace No Record
(City, town, or county) (State or foreign country)

14. Maiden name Rose

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

16. (a) Informant Rose Phillips

(b) Address Cottleville, Kans.

17. (a) Burial (b) Date thereof 2-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Carmel Cem.

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

19. (a) 5-9-44 (b) D. E. Brown
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8 of year 1944 hour 8:30 minute P M.
21. I hereby certify that I attended the deceased from April 26, 1944 19 to May 8 19 44
that I last saw him alive on May 8 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death coronary occlusion
Due to arteriosclerosis

Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: afa
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 J. Hoffman M.D. (M. D. or other) _____
Address 404 Parkside Bldg Date signed 5-9-44

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

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.....

R. L. Lewis

Licensed Embalmer No.

3110

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.