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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 20874

Registration District No. FILED JUL 15 1944 Primary Registration District No. 1002 Registrar's No. 2843

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C. (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 1 wk (Specify whether years, months or days) In this community 20 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. 2850 Tracy (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3. (a) PRINT FULL NAME Rosa Silver
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Fe
5. Color or race W
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years about 67 Months Days If less than one day hr. min.
9. Birthplace Poland (City, town, or county) (State or foreign country) 4
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name unknown
13. Birthplace unknown (City, town, or county) (State or foreign country) 4
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country) 4
16. (a) Informant Mr. Ross.
(b) Address Appleman Home
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-44 (Month) (Day) (Year)
(c) Place: burial or cremation Sheffield, Ark.
18. (a) Signature of funeral director H. Hyman & Son
(b) Address K.C. Mo.
19. (a) 7-8-44 (Date received local registrar) (b) M. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8 year 1944 hour 6:00 minute A M.
21. I hereby certify that I attended the deceased from July 5 1944 to July 8 1944 that I last saw her alive on July 7 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Hypertension
Due to Cardiac Vascular Renal Disease
Other conditions Senility
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy 131 A

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? (Specify type of place)
While at work?
(e) Means of injury
23. Signature Gerald Lapman M.D. (Name of physician or other)
Address Bay. Bldg. Date signed 7-8-44

(Licensed Embalmer's Statement on Reverse Side)

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 2744 Francis Walton, Registered Apprentice No. ..... working under my personal supervision.

Signed J. K. Regin

Licensed Embalmer No. 2744

P. O. Address K. City

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.