

7. S. No. 2  
00M-2-43  
Rev. 5-17-39  
I X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26844

FILED SEP 7 1944

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

Registration District No. 179

Primary Registration District No. 1002

Registrar's No. 3448

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town K.C. - Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Mary Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 hrs. 34 min.  
In this community 4 hrs. 34 min.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town K.C.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3021 Harrison  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME

Baby Boy Halpern

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex male 5. Color or race w  
6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_ years

7. Birth date of deceased: 8-18-44  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 4 hr. 34 min.

9. Birthplace: K.C. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Man Born

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Abraham J. Halpern  
13. Birthplace Midat Cather. Poland  
(City, town, or county) (State or foreign country)  
14. Maiden name Rosal Jacobs  
15. Birthplace Poland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr Abraham Halpern  
(b) Address 3021 Harrison

17. (a) Burial (b) Date thereof 8-19-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Shelfield Cem

18. (a) Signature of funeral director J.P. LOUIS Funeral Home  
(b) Address Kansas City, Mo.

19. (a) 8-22-44 (b) T. E. Brown  
(Date received local registrar) (Registrar's name)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 18 year 1944 hour 7 minute 30 M.

21. I hereby certify that I attended the deceased from 8-18-44 to Aug 18 - 19-44  
that I last saw him alive on Aug 18 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Premature birth

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? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature Therese Brown (M. D. or other) MD  
Address 1300 Poplar Date signed 8-22-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

8338

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**