S. No. 2
M—2-43
5-17-39
X35697

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

26986

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 199 Primary Registration District No. 1002 Registrar's No. 3451

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: Menorah Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether

In this community 60 yrs. years, months or days)

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. 1320 E. 27th (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Josef Segelbohm

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex MO

5. Color or race W.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Julia Segelbohm

6. (c) Age of husband or wife if alive 60 years

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

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

9. Birthplace Russia (City, town, or county) 6 (State or foreign country)

10. Usual occupation Tailor

11. Industry or business

FATHER
12. Name Abraham Segelbohm
13. Birthplace Russia (City, town, or county) 6 (State or foreign country)

MOTHER
14. Maiden name Libby Loebman
15. Birthplace Russia (City, town, or county) 6 (State or foreign country)

16. (a) Informant Mrs Julia Segelbohm

(b) Address 1320 E. 27

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/44 (Month) (Day) (Year)

(c) ~~Place~~: burial ~~or cremation~~ Rose Hill Cem.

18. (a) Signature of funeral director Carroll Davidson

(b) Address 3024 Troost ave.

19. (a) 8-22-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 20 day Aug year 1944 hour 12 minute 50 M.

21. I hereby certify that I attended the deceased from 15th June, 1944, to 8-20, 1944, that I last saw him alive on Aug 20, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis

Due to

Due to

Other conditions 940 (Include pregnancy within 3 months of death)

Major findings:
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature A. Illoovis Gunsten (M. D. or other)

Address 420 Prof Bldg Date signed 8-22-44

(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.....

..... Registered Apprentice No.....,

working under my personal supervision.

Signed Katherine E. Ward

Licensed Embalmer No. 3648

P. O. Address Kansas 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.

S. No. 2B
DM—5-43
I X36930

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. Sept.

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 3451

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: Menorah Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 da (Specify whether

In this community 60 yr. years, months or days)

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 .....

3. (a) PRINT FULL NAME Josef Segelbohm

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased March (Month) 3 (Day) 1875 (Year)

8. AGE: Years 69 Months 5 Days 17 If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

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

19. (a) 8-22-44 (Date received local registrar) (b) Dr. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

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

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions ..... (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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY

269986