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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30192

FILED OCT 2 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3799

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 O
(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 36 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 41

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 722 Virginia
(If rural, give location)

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

If yes, name country O

3. (a) PRINT FULL NAME Mamie Kraft

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Fe

5. Color or race Wh

6. (a) Single, widowed, married, divorced 2

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

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

7. Birth date of deceased Not Known
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
63	—	—	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

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

MOTHER
14. Maiden name Not Known
15. Birthplace Not Known Y
(City, town, or county) (State or foreign country)

16. (a) Informant Nathan Kraft
(b) Address K. C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-44 (Month) (Day) (Year)
(c) Place: burial or cremation Sheffield Cem.

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

19. (a) 9-20-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18
year 1944 hour 9 minute 25 A. M.

21. I hereby certify that I attended the deceased from IX/15/44, 19 to IX/18/44, 19;
that I last saw her alive on IX/18/44, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death acute Leucemia

Due to

Due to

Other conditions
(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.

74a

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 L. R. Wyman (M. D. or other)

Address IX/19/44 Date signed

(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.....

Licensed Embalmer No. 8110

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.