V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 13 1944

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33155

Primary Registration District No. 1002.

Registrar's No. 4334

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: K. C. General Hospital No. 1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 mo. 14 days (Specify whether years, months or days)
In this community: 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 48
(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 4014 Prospect 2
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Jacob Gotlieb
3. (b) If veteran, name war: No
3. (c) Social Security No. 496-26-2934
4. Sex: 0 Male
5. Color or race: W/M
6. (a) Single, widowed, married, divorced: /
6. (b) Name of husband or wife: Anna Gotlieb
6. (c) Age of husband or wife if alive: 50 years
7. Birth date of deceased: unknown (Month) (Day) (Year)
8. AGE: Years 54 | Months | Days | If less than one day ___ hr. ___ min.
9. Birthplace: 4 Poland (City, town, or county) (State or foreign country)
10. Usual occupation: Tailor
11. Industry or business:
FATHER 12. Name: Lazor Jabin
FATHER 13. Birthplace: 4 Poland (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Fannie
MOTHER 15. Birthplace: 4 Poland (City, town, or county) (State or foreign country)
16. (a) Informant: Phillip Jabin
(b) Address: K. C. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-28-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Sheffield Cem
18. (a) Signature of funeral director: J. D. Lovis Funeral Home
(b) Address: K. C. Mo.
19. (a) 10-28-44 (Date received local registrar) (b) T. G. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct. day: 27 year: 1944 hour: 11 minute: 58 P.M.
21. I hereby certify that I attended the deceased from Sept. 13, 1944 to Oct. 27, 1944; that I last saw him alive on Oct. 27, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma of esophagus	
Due to	
Due to 4 b a	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: None

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: 0

23. Signature: A. E. Upcher (M. D. or other) MD
Address: Med. Dir. 25 McGee Date signed: 10-28-44

(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.....

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.