S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 4 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40160

Registration District No. 149 Dr. Printz. Primary Registration District No. 1002. Registrar's No. 5228

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 Hospt. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days (Specify whether In this community 15 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 42

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 3

(d) Street No. Milner Hotel (If rural, give location) 2

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

If yes, name country

3. (a) PRINT FULL NAME Zelda Hirsch

3. (b) If veteran, name war No.

3. (c) Social Security No. dont know

4. Sex Fe. 1

5. Color or race W.

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

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 Aprox 58 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Seamstress

11. Industry or business Hartzfelds

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs. Lillian Levinson

(b) Address St. Louis Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/44 (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn Cem.

18. (a) Signature of funeral director H. Tigerman & Sons

(b) Address K. C. Mo.

19. (a) 12-23-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 14 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from 12-8-44, 19 , to 12-14, 1944 that I last saw her alive on 12-14, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Post operative shock.

Due to Resection of Carcinoma of Colon

Due to

Other conditions (Include pregnancy within 3 months of death) 46

Major findings: Of operations Ca of Colon

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) no

(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 [signature] Printz (M. D. or other) M D

Address 1025 Prof Bldg Date signed 12/21/44

(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 [redacted] or by Francis Walton, Registered Apprentice No. 2744 working under my personal supervision.

Signed J. K. Tiginian

Licensed Embalmer No. 2744

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.