

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
(a) County Jackson  
(b) City or town W. Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Memorial Hosp. O  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 95 days  
(Specify whether  
In this community 26 yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Jackson 48  
(c) City or town W. Mo. 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 235 Ward Parkway  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country 11

3. (a) PRINT FULL NAME MARK TAXMAN  
(b) If veteran, name war no  
(c) Social Security No. none

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Mayer Taxman 6. (c) Age of husband or wife if alive 1884 years  
7. Birth date of deceased Jan. 17 1884  
(Month) (Day) (Year)

8. AGE: Years 60 Months 11 Days 25 22 hr. 5 min. If less than one day

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

10. Usual occupation Housewife

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

MOTHER FATHER  
12. Name Phillip Schlafer  
13. Birthplace Russia  
(City, town, or county) (State or foreign country)  
14. Maiden name Rebecca Frazer  
15. Birthplace Russia  
(City, town, or county) (State or foreign country)

16. (a) Informant Mayer Taxman  
(b) Address 235 Ward Parkway

17. (a) Entombment (b) Date thereof 1/11/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pine Hill Mausoleum

18. (a) Signature of funeral director Carroll Doudon

(b) Address 302 47th St.

19. (a) 1-10-45 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day Jan  
year 1945 hour 8 minute 50 P. M.

21. I hereby certify that I attended the deceased from Oct 1 1944 to Jan 9 1945  
that I last saw h. er alive on Jan 9 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of descending Colon Duration 4 mos.  
Due to \_\_\_\_\_  
Due to 46 2

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Cancer of colon with metastasis to liver PHYSICIAN \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature Alfredo Justus (M. D. or other) \_\_\_\_\_  
Address 420 Prof. Bldg Date signed 1-10-45

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

**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 Kathryn E. Davids  
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.**