V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

48
3
8

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1945

Registration District No. 749

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 12930

Registrar's No. 1509

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas (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 18 day (Specify whether

In this community 31 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED: 49

(a) State Missouri (b) County Jackson

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

(d) Street No. 3129 Wayne (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Ben Jacobson

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex M

5. Color or race Wh.

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

6. (b) Name of husband or wife Martha

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

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

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Auto Wrecking Bus

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Not Known (City, town, or county) (State or foreign country)

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

16. (a) Informant Harry Jacobson
(b) Address K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-45 (Month) (Day) (Year)
(c) Place: burial or cremation Sheffield Cem

18. (a) Signature of funeral director Louis Funeral Home
(b) Address City

19. (a) 4-4-45 (Date received local registrar) (b) G. Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 3 year 1945 hour 8 pm minute M.

21. I hereby certify that I attended the deceased from ~~Dec~~ 3-18-45, 19, to 4-3-45, 19;
that I last saw him alive on 4-3 at 8 pm, 1945;
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Generalized peritonitis

Due to evisceration of abdominal contents

Due to (Postoperative)

Other conditions appendectomy 3-19-45
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Not performed

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) Accident
(b) Date of occurrence 3-24-45
(c) Where did injury occur? K-C. Jackson, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Hosp. Menorah. (Specify type of place)
While at work? no (e) Means of injury Coughing

23. Signature [illegible] (M. D. or other) M.D.
Address 1028 Prof Bldg Date signed 4-4-45

(Licensed Embalmer's Statement on Reverse Side)

129
195-21
121:2

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.