

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23203**

**FILED** JUL 29 1945  
Registration District No. **1001**

Primary Registration District No. **1001**

Registrar's No. **3037**

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

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Kanons city mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Memorial Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days  
(Specify whether years, months or days) 43 yrs

In this community \_\_\_\_\_  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Jackson 48

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

(d) Street No. Park Central Hotel 8  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** FANNIE SHAPIRO

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race Jewish

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

6. (b) Name of husband or wife Jacob R Shapiro 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased unknown  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 18 year 1945 hour 9 minute 15 AM

21. I hereby certify that I attended the deceased from July 7 45 to July 18 45  
that I last saw h. or alive on July 18 1945  
and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<u>65</u>			hr. _____ min. _____

Immediate cause of death: Pulmonary occlusion

Due to Diabetes mellitus

Due to \_\_\_\_\_

Duration Sudden 5 yrs

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 61

10. Usual occupation House wife

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

MOTHER FATHER

12. Name unknown Russia

13. Birthplace unknown Russia l.  
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown Russia l.  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

16. (a) Informant Jacob R Shapiro

(b) Address Park Central Hotel

17. (a) Burial (b) Date thereof 7 20 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shelburne

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? \_\_\_\_\_

18. (a) Signature of funeral director Howard Lynell

(b) Address 3800 Woodlawn

19. (a) 7-20-45 (b) Steldine Tolmes  
(Date received local registrar) (Registrar's signature)

While at work \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature J. Morris Swanson (M. D. or other)

Address 420 Proj Bldg Date signed 7-19-45

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**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.....

*W. L. Lewis*

Licensed Embalmer No.....

*3110*

P. O. Address.....

*K. C. No*

**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.**