No. 2
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17-39
X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40012

FILED DEC 28 1945

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5061

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: ST JOSEPH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 DAYS
In this community 35 YEARS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 4238 E 60TH TERRACE
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - - - - -

3. (a) PRINT FULL NAME JOSEPHINE BARBARA BLOOM (ALICE VOCHATZER)

3. (b) If veteran, name war No

3. (c) Social Security No. 500-03-5430

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife MR. SAMUEL BLOOM

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased OCTOBER 17 1910 (Month) (Day) (Year)

8. AGE: Years 35 Months 1 Days 20 If less than one day ____ hr. ____ min.

9. Birthplace KANSAS CITY (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business - - - - - - -

FATHER
12. Name LOUIS VOCHATZER
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

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

16. (a) Informant MR. SAMUEL BLOOM
(b) Address 4238 EAST 60TH ST TERRACE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 10 1945 (Month) (Day) (Year)
(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director D. H. Newcomer Sons
(b) Address 1401 BRUSH CREEK BLVD

19. (a) 12-10-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 7TH year 1945 hour 5 minute 0 P.M.

21. I hereby certify that I attended the deceased from Pathologist, 19..; that I last saw h.. alive on ..., 19..; and that death occurred on the date and hour stated above.

Immediate cause of death: Subacute yellow atrophy and cirrhosis of the liver

~~Due to~~ of unknown etiology

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 125.00

Of autopsy as above

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)
(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 Laine Sherwood (M. D. or other)
Address Pathologist Date signed 12-8-45

(Licensed Embalmer's Statement on Reverse Side) St. Joseph Hospital, K.C., Mo.

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. Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address. K C Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.