

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED MAY 20 1946

State File No. 16774
Registrar's No. 2052

Registration District No. 149 Primary Registration District No. 1002

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

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:
905 Grand Ave. /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 2 MOS.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
 (d) Street No. Robt. E. Lee Hotel 8
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No) 0
 If yes, name country _____

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

4. Sex M 0 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Golda Nathan
 6. (c) Age of husband or wife if alive 50 years
 7. Birth date of deceased Aug. 10, 1893
(Month) (Day) (Year)

8. AGE: Years 52 Months 8 6 Days 24
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Insurance Salesman

11. Industry or business _____

MOTHER FATHER { 12. Name Morris Nathan 6

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

14. Maiden name Sarah (Unknown)

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

16. (a) Informant Dr. Burnett Nathan

(b) Address Chicago, Ill.

17. (a) Removal (b) Date thereof: 5/5/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chicago, Ill.

18. (a) Signature of funeral director J.P. Louis
 (b) Address 3400 Woodland Ave.

19. (a) 5-5-46 (b) Sheldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 4
 year 1946 hour 8:40 minute a M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
 that I last saw h_____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Skull fracture

Due to Multiple fractures of entire body

Due to _____

Other conditions 164e
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy no
History & Inspection

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence 5-4-46

(c) Where did injury occur? no. Jackson Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place
(Specify type of place)

While at work? no (e) Means of injury Fall

23. Signature James Cahill (M. D. or other) 3
 Address 1424 1st St Date signed 5-5-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

DEC 17 1946

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..... *B. A. Legan*
Licensed Embalmer No..... *3979*
P. O. Address..... *H.C. Md*

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.