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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33872**

FILED NOV 1 1946

Registration District No. **147**

Primary Registration District No. **5569**

Registrar's No. **239**

1. PLACE OF DEATH:

(a) County **JACKSON**

(b) City or town **KANSAS CITY Rural**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
8905 EAST 66TH ST. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community **34 YEARS**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **JACKSON 48**

(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL.")

(d) Street No. **8905 EAST 66TH ST. 1**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **SADY KLEIN**

3. (b) If veteran, name war **NO**

3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **7**
year **1946** hour **2:00** minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____ **Sept 7** 19**46**

that I last saw her alive on **Sept 7** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death
Carcinoma of Cervix

4. Sex **FEMALE** 5. Color or race **WHITE**

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

6. (b) Name of husband or wife **MAX KLEIN**

6. (c) Age of husband or wife if alive **50 years**

7. Birth date of deceased **JULY 17 1899**
(Month) (Day) (Year)

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

8. AGE:

Years	Months	Days	If less than one day
47	1	16	hr. _____ min. _____

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

10. Usual occupation **HOUSE WIFE**

11. MOTHER FATHER

12. Name **RACHMEL GRUMZINSKY**

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

14. Maiden name **UNKNOWN**

15. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

48A

16. (a) Informant **MAX KLEIN**

(b) Address **8905 E. 66TH ST. H.C. MO**

17. (a) **BURIAL** (b) Date thereof **9-5-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **3 HEFFIELD CEM.**

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 **J.P. Lewis Funeral Home**

(b) Address **3400 WOODLAND AVE. H.C. MO**

19. (a) **9/5/46** (b) **Pauline Darwin**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature **Pauline Darwin** (M. D. or other) **0**

Address **100 Plaza Med Bldg.** Date signed **9/4/46**

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

DR. J.J. COCHRANE.
PLAZA MED. BLDG.

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E-M
K I

JAN 3 1950

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. G. Legan
Licensed Embalmer No. 3979
P. O. Address H. C. W.

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.

Registration District No. 147 Primary Registration District No. 5569

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town RURAL B. BROOKING
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Sady Klem

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

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

8. AGE: Years 47 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____
(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 9-5-46 (b) Mildred Harvey
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 17 Year 1946 hour _____ minute _____ M.

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

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings:
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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

33872