

No. 2
12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4912

State File No. _____

FILED MAR 10 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 932

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:
5209 Charlotte
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 1/2 yrs. (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 5209 Charlotte
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William H. KALIS

3. (b) If veteran, name war no
3. (c) Social Security No. 492-03-4310
No. unknown

MEDICAL CERTIFICATION
DATE OF DEATH: Month 28 February
year 1947, hour 8 10 minute P M.
21. I hereby certify that I attended the deceased from day of death
to 19 to 19
that I last saw him alive on Feb 28, 1947
and that death occurred on the date and hour stated above.
Immediate cause of death Cardiac failure Duration _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased May 27, 1887
(Month) (Day) (Year)

8. AGE: Years 59 Months 9 Days 1
If less than one day _____ hr. _____ min.

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

10. Usual occupation Saleman

11. Industry or business _____

12. Name Harris Kalis.

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

14. Maiden name Jeanette Gertrude Spurling

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

16. (a) Informant Mrs. Wm. Kalis

(b) Address 5209 Charlotte, Kansas City, Mo.

17. (a) Burial (b) Date thereof 3/2/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cem.

18. (a) Signature of funeral director J. P. Louis Funeral Home

(b) Address 3400 Woodland, K.C. Mo.

19. (a) 3-1-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

Due to Coronary thrombosis
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

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)
(c) Means of injury 0

23. Signature Mark H. Marks MD (M. D. or other) _____
Address 720 Greenfield Bldg. Date signed 3-1-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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. 2110.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 932

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: 5209 Charlotte
(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 William H. Kalis

- 3. (b) If veteran, name war _____
- 3. (c) Social Security No. 495-05-4310

4. Sex _____	5. Color or race _____	6. (a) Single, widowed, married, divorced _____
--------------	------------------------	---

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

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

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

- 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) 3-1-47 (b) Steraldine Holmes
(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 _____ Day _____
Year 1947 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 _____

Duration _____

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-4912