S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 998

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: Menorah Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 35 yrs 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. 4126 Prospect 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country N

3. (a) PRINT FULL NAME Samuel Caplan

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

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

6. (b) Name of husband or wife Fanny
6. (c) Age of husband or wife if alive 66 years

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

8. AGE: Years app. 71 | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Poland (State or foreign country)
10. Usual occupation Retired Grocer
11. Industry or business

FATHER
12. Name Mendal Caplan
13. Birthplace (City, town, or county) Poland (State or foreign country)

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

16. (a) Informant Rose Keane
(b) Address K.C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-47 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Carmel Cem

18. (a) Signature of funeral director Louis Funeral Home
(b) Address 3400 Woodland

19. (a) 3-5-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 2 year 1947 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from 1942, 19__, to III/2/47, 19__; that I last saw him alive on III/2/47, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary insufficiency — Duration

Due to hardening of arteries

Due to

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

Major findings:
Of operations
Of autopsy 95C

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 D. R. [illegible] (M.D. or other)
Address 1710 Bryant Bldg Date signed III/4/47

(Licensed Embalmer's Statement on Reverse Side)

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. 3110

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.