

FILED SEP 16 1947
Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 3815

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution Memorial Hosp.
(If not in hospital or institution, write street name and location)

(d) Length of stay: In hospital or institution 7 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME ABRAHAM STEINDLER

3. (b) If veteran, name war No

3. (c) Social Security No. 510-16-3601

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased August 9 - 1861
(Month) (Day) (Year)

8. AGE: Years 86 Months 0 Days 26 - If less than one day hr. min.

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

10. Usual occupation Hotel Clerk

11. Industry or business

MOTHER FATHER

12. Name Solomon Steindler

13. Birthplace Austria 4
(City, town, or county) (State or foreign country)

14. Maiden name Sophie Fleischer 1

15. Birthplace Austria 1
(City, town, or county) (State or foreign country)

16. (a) Informant Sean Bloch

(b) Address 3938 Broadway

17. (a) Burial (b) Date thereof 9/7/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Zion Seaworth, Ind.

18. (a) Signature of funeral director Carroll Davison

(b) Address 3024 Trust

19. (a) 9-10-47 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. County Jackson 48

(c) City or town K.B. 3
(If outside city or town limits, write "RURAL")

(d) Street No. 3938 Broadway 8
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4
year 47 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from August 31 1947 to Sept 6 1947
that I last saw him alive on Sept 3 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia 3 days
hype Niso 5 days

Due to Intracapsular Fracture 5 days

Due to

Other conditions Diabetes Mellitus 3 years
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations 1860

Of autopsy 18

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence August 31, 1947 123

(c) Where did injury occur? Kansas City, Mo.
(City or town) (County) (State)

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

While at work? No (e) Means of injury Fall 0

23. Signature Jack W. Gray (M. D. or other) MD.
Address 666 Popple Hill Date signed Sept 5, 47

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

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.....

P. O. Address.....

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.

10. Usual occupation *Retired* (City, town, or county) (State or foreign country)

11. Industry or business

MOTHER FATHER { 12. Name *Solomon Steindler*

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

MOTHER { 14. Maiden name *Sophie Fliche*

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

16. (a) Informant *Leon Bloch*

(b) Address *K.C. Mo.*

17. (a) *Burial* (b) Date thereof *9/7/47*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Seeworth, Mo.*

18. (a) Signature of funeral director *Carroll-Pardon*

(b) Address *3024 Trenton*

19. (a) *9-6-47* (b) *Sheraldine Holmes*
(Date received local registrar) (Registrar's signature)

Other conditions *Diabetes Mellitus* *3 years*
(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) *Accident*

(b) Date of occurrence *Aug 31, 1947*

(c) Where did injury occur? *Kansas City, Jackson, Missouri*
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In our home

While at work? *No* (Specify type of place) (e) Means of injury *Fall*

23. Signature *Jack W. Wray* (M. D. or other) *MO*

Address *206 Apple Blg.* Date signed *Sept 5, 1947*
Kansas City, 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

Kathryn E. Davidson

Licensed Embalmer No.

3648

P. O. Address

A. 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.