

UNITED STATES DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

4968

National Office of Vital Statistics

FILED DEC 9 1947

Registration District No. 2/49

Primary Registration District No. 1002

Registrar's No. ....

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: St. Joseph  
(If not in hospital or institution, write street number or location) 1 day  
(d) Length of stay: In hospital or institution 40 years  
In this community 40 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4223 Highland  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country no

3. (a) PRINT FULL NAME BERTHA LEIBOWITZ

(b) If veteran, name war no (c) Social Security No. none

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Louis 6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased unknown  
(Month) (Day) (Year)

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

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Louis Leibowitz

(b) Address 4223 Highland

17. (a) burial (b) Date thereof 11-27-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheffield

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

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

19. (a) 11-26-47 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26 year 1947 hour no minute no M.

21. I hereby certify that I attended the deceased from 7-7-43 to Nov-26 1947  
that I last saw him alive on Nov 25 1947  
and that death occurred on the date and hour stated above.  
Duration

Immediate cause of death: Cerebral collapse (shock) 8 hrs

Due to: Internal bleeding  
intestinal obstruction  
Acute Peritonitis

Other conditions: Hypertension  
(include pregnancy within 1 year)

22. Major findings: 1225  
Of operations

Of autopsy Refused

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 place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Dorenda [unclear] (M. D. or \_\_\_\_\_)

Address 1500 [unclear] Date signed 11-26-47

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

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**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.**