No. 2
-1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAR 27 1948

Registration District No. 149

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 8765

Registrar's No. 1162

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

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: 3520 - West - 12th St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County 997
(c) City or town Brooklyn 30
(If outside city or town limits, write "RURAL")
(d) Street No. unknown 02
(If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Irving Kaplin
3. (b) If veteran, name war unknown
3. (c) Social Security No. unknown
4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife unk.
6. (c) Age of husband or wife if alive unk. years
7. Birth date of deceased Unknown (Month) (Day) (Year)

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

9. Birthplace unknown (City, town, or county) 9 (State or foreign country)
10. Usual occupation Traveling Salesman
11. Industry or business
FATHER
12. Name unknown
13. Birthplace (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) 9 (State or foreign country)
16. (a) Informant Coroner's office
(b) Address K-C. Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/15/48 (Month) (Day) (Year)
(c) Place: burial or cremation Brooklyn N.Y.
18. (a) Signature of funeral director Carroll - Davidson
(b) Address 3024 Troost
19. (a) 3-15-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13
year 1948 hour 8:10 minute a M.
21. I hereby certify that I attended the deceased from Coroner, 19, to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary sclerosis
Due to Arterio sclerosis
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 930
Of autopsy no
History & Inspection

Duration

PHYSICIAN
Underline the cause of 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 3
23. Signature James C. Walker (M. D. ~~or other~~) Coroner
Address 1424 [illegible] Date signed 3-15-48

Jefferson City Printing Co.

(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.....

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.

No. 2B
—3-45
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 12 1948

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. 1162

SUPPLEMENTARY

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:

(If not in hospital or institution, write street number or location)

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

In this community unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State NEW YORK (b) County KINGS

(c) City or town BROOKLYN

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

(d) Street No. 3359 BEDFORD AVE.

(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Irving ~~Kaplan~~ KAPLAN

3. (b) If veteran, name war unk.

3. (c) Social Security No. unknown

4. Sex

5. Color or race

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

6. (b) Name of husband or wife SONIA KAPLAN

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

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

8. AGE: Years 42 Months Days If less than one day hr. min.

9. Birthplace NEW YORK CITY (City, town, or county) N.Y. (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER

12. Name RUBIN SAMUEL KAPLAN

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

MOTHER

14. Maiden name GUSSIE HEICKLIN

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

16. (a) Informant SONIA KAPLAN

(b) Address 3359 BEDFORD AVE. B'KLYN

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 3-15-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 13 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

5-8765