

S. No. 300
M-10-47
7-5-17-39
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19536

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 26 1948

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2496

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:
Trinity Lutheran Hosp. O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 weeks
(Specify whether _____)

In this community 43 years
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. 1420 East 9th St.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Mrs Elsie Karam

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13th
year 1948 hour 11.27 A.M. minute _____ M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Sam Karam

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased: April 11 1898
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 19 48 to 13 June 19 48
that I last saw him alive on 13 June 19 48
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>62</u>	<u>2</u>	<u>2</u>	hr. _____ min. _____

Immediate cause of death: Pulmonary Embolism

Duration 2 days

9. Birthplace: Kansas City, Missouri
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 52 K

10. Usual occupation Cafe Operator

Major findings: Carcinoma of Bladder

Of operations _____

Of autopsy _____

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

11. Industry or business _____

12. Name Joseph Carpenter

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

14. Maiden name Ermin Lemburth

15. Birthplace Bowling Green, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Sam Karam

(b) Address 1420 East 9th St.

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? _____

17. (a) Removal (b) Date thereof 6-15-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope N.C. Maus.

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

(f) Means of injury _____

18. (a) Signature of funeral director Thos. E. Quirk

(b) Address 4316 Troost Ave.

23. Signature H E Carlson (M. D. or other) _____
Address Prof. of Med Date signed 13 June

19. (a) 6-14-48 (b) Geralline Holmes
(Date received local registrar) (Registrar's signature)

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.....
Thomas E. Zwick

Licensed Embalmer No.....
3775

P. O. Address.....
J. 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.