No. 300
10.48

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

FILED MAR 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8317

BIRTH NO. 49-014450 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 815

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (in this place): 2 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Menorah Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 4430 Paseo.

3. NAME OF DECEASED (Type or Print)
a. (First): Baby
b. (Middle): John
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): Feb. 19, 1949

5. SEX: Female
6. COLOR OR RACE: Wh
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Feb. 19, 1949
9. AGE (In years last birthday): 0 — IF UNDER 1 YEAR: Months 0, Days 0 — IF UNDER 24 HRS.: Hours 2, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): K.C. Mo.
12. CITIZEN OF WHAT COUNTRY?: U. S. a.

13a. FATHER'S NAME: Sol Cohn
13b. MOTHER'S MAIDEN NAME: Zona Zalinsky
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME: Sol Cohn — **ADDRESS**: 4430 Paseo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Congenital atelectasis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Pre-eclamptic Toxemia
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
7690

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Feb. 19, 1949, *to* 2-19, 1949, *that I last saw the deceased alive on* 2-19, 1949, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Jacob P. Farney (Degree or title): MD
23b. ADDRESS: 6305 Brookside Blvd
23c. DATE SIGNED: 2-21-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Feb. 20, '49
24c. NAME OF CEMETERY OR CREMATORY: Sheffield
24d. LOCATION (City, town, or county) (State): K.C. Mo.

DATE REC'D BY LOCAL REG.: 2-22-49
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: N. P. Harris Funeral Home K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

Not Embalmed

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.....

..... Student Embalmer No. .....,

working under my personal supervision.

Not Embalmed

Student .....
Student Embalmer

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.