

FILED APR 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 8359
1063

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>mo.</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>5</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3-7-1949</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Menorah Hosp</u>				d. STREET ADDRESS (If rural, give location) <u>Appleman Home 2850 TROOST</u>			
3. NAME OF DECEASED (Type or Print) <u>BESSIE</u>		a. (First)		b. (Middle)		c. (Last) <u>FINE</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>		8. DATE OF BIRTH <u>unknown</u>		9. AGE (In years last birthday) <u>app. 75</u>	
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) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>unk</u>	
13a. FATHER'S NAME _____		13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Joe Rigerman</u> ADDRESS <u>2738 Prospect</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized Peritonitis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of Colon</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>155K</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> ? 	
19a. DATE OF OPERATION <u>2/28/49</u>		19b. MAJOR FINDINGS OF OPERATION <u>carcinoma of sigmoid colon</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>2-15</u> , 19 <u>49</u> , to <u>3-7</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>2-7</u> , 19 <u>49</u> , and that death occurred at <u>1:00 a.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Joseph H. Prutz M.D.</u>				23b. ADDRESS <u>1103 Grand</u>		23c. DATE SIGNED <u>3-8-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3/8/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ST JOSEPH MO</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph MO.</u>	
DATE REC'D BY LOCAL REG. <u>3-8-49</u>		REGISTRAR'S SIGNATURE <u>Sheldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joe Rigerman</u>		ADDRESS <u>St. Joseph MO.</u>	

(Licensed Embalmer's Statement of Reverse Side)

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.....

....., Student Embalmer No.

working under my personal supervision.

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.