

FILED MAR 27 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 10107

1271

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 1271	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. LENGTH OF STAY (In this place) 6.5 years		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City		2/18	
d. FULL NAME OF HOSPITAL OR INSTITUTION Menorah Medical Center				d. STREET ADDRESS (If rural, give location) 626 W 58th St 3848			
3. NAME OF DECEASED (Type or Print) Minnie		a. (First)		b. (Middle)		c. (Last) Stern	
4. DATE OF DEATH 2-28-53		5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	
8. DATE OF BIRTH 6-15-83		9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personal Dept. Prin. Clerk Records Rm. City		11. BIRTHPLACE (City and State or Foreign Country) New York, N. Y.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Ernest Lukin		13b. MOTHER'S MAIDEN NAME Rose Rabinowitz		14. NAME OF HUSBAND OR WIFE Max Stern	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 486-366839		17. INFORMANT'S SIGNATURE OR NAME Albert M. Stern			
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) Cancer of Colon				INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b)  DUE TO (c)				153X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Cancer of Transverse Colon				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)		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 Jan. 31, 1953, to 2/28, 1953, that I last saw the deceased alive Feb. 27, 1953, and that death occurred at 5:34 p.m., from the causes and on the date stated above.							
23a. SIGNATURE Philip A. Halperin M.D.				23b. ADDRESS 409 Proj Bldg		23c. DATE SIGNED 3-1-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-1-53		24c. NAME OF CEMETERY OR CREMATORY Sheffield		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
DATE REC'D BY LOCAL REG. 3-2-53		REGISTRAR'S SIGNATURE Seraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE Louis Funeral Home		ADDRESS K.C. Mo.	

(Licensed Embalmer's Statement on 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 A. L. Louis

Licensed Embalmer No. 3110

P. O. Address: K. E. 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.