

FILED DEC 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41266**
5624

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 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 OR TOWN <u>Kansas city</u> (Outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (in this place) <u>33 yrs.</u>		c. CITY OR TOWN <u>Kansas city</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorah Med. Center</u> (If not in hospital or institution, give street address or location) STREET ADDRESS <u>1011 Chestnut</u>		3618	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sol.</u> b. (Middle) <u>Trachtman</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 6-54</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-15-12</u>
9. AGE (In years last birthday) <u>42</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber 2907 E 31st</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Russia 6</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Samuel Trachtman</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah (Unknown)</u>	14. NAME OF HUSBAND OR WIFE <u>Ruth</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknowns) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>486-10-6442</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ruth Trachtman</u> ADDRESS <u>Home</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Vascular Accident</u>		<u>2 hrs</u>
	ANTECEDENT CAUSES DUE TO (b) <u>Hypertension, Renal</u> DUE TO (c) <u>Nephritis, chronic</u>		<u>1/2 yrs</u> <u>4 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>592X</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 10-21, 1954 to 12-5, 1954 that I last saw the deceased alive on 12-5, 1954, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>B. Marcus Heller</u> (Degree or title) <u>MD</u>	23b. ADDRESS <u>409 C. 6th</u>	23c. DATE SIGNED <u>12-6-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12-7-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sheffield</u>
DATE REC'D BY LOCAL REG. <u>12-7-54</u>	REGISTRAR'S SIGNATURE <u>newa Minshall</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Fun'l Home</u> ADDRESS <u>K.C. Mo.</u>		

(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.....
Signature of Student Embalmer

Signed *Geary Buffington*

Licensed Embalmer No. *2750*

P. O. Address *D. C. M.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.