

FILED AUG 17 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26457

2923

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
a. COUNTY JACKSON

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE Mo. b. COUNTY Jackson

b. CITY OR TOWN KANSAS CITY  
c. LENGTH OF STAY (in this place) 16 yrs.

c. CITY OR TOWN Kansas City  
d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION MENORAH MEDICAL CENTER 95

STREET ADDRESS (If rural, give location) 8251 President Ct. 3950

3. NAME OF DECEASED  
a. (First) IRVING b. (Middle) (CHICK) c. (Last) SASKIN

4. DATE OF DEATH (Month) (Day) (Year) 7 8 55

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Single

8. DATE OF BIRTH 10-24-1913

9. AGE (in years last birthday) 41

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner - Chicks Driving Range - 89th + Troost

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) Brooklyn, N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Abraham Saskin

13b. MOTHER'S MAIDEN NAME Lena Frumkin

14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WW II

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Myer Shapiro 638 E. Gregory

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) Respiratory paralysis  
ANTECEDENT CAUSES  
DUE TO (b) Pneumonia  
DUE TO (c) Hypertension - nephritis acute  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH  
590X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION no 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 7/5, 1955, to 7/8, 1955, that I last saw the deceased alive on 7/8, 1955, and that death occurred at 4:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE Delon A. Williams, M.D. (Degree or title) C.D. Delon A. Williams M.D.

23b. ADDRESS 806 P. J. Bldg.

23c. DATE SIGNED 7/9/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-10-55

24c. NAME OF CEMETERY OR CREMATORY Sheffield

24d. LOCATION (City, town, or county) (State) Kansas City, Mo.

DATE REC'D BY LOCAL REG. 7-9-55

REGISTRAR'S SIGNATURE Neva Marshall

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Louis Fun'l Home K.C. Mo.

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

4838

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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 *P. L. Louis*.....

Licensed Embalmer No. *311*.....

P. O. Address *K. E. 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.