

FILED JAN 14 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41699

STATE FILE NUMBER 5527

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City, Missouri</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b>				Length of stay in 15. <b>48 yrs.</b>		d. STREET ADDRESS <b>4511 Virginia</b> (If outside, give location)		
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Solomon</b> Last <b>Rittmaster</b>		4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1956</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-86</b>	9. AGE (In years last birthday) <b>70</b>	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) <b>Tailor - 6 W 10th</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Vishay, Lithuania</b>			
13. FATHER'S NAME <b>David Rittmaster</b>				14. MOTHER'S MAIDEN NAME <b>Libby (Unknown)</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Fannie Rittmaster</b>		Address <b>Home</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
Conditions, if any, which gave rise to, above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						<b>4201</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>a.</b>					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE		
21. I attended the deceased from <b>12-16-56</b> to <b>12-18-56</b> and last saw her alive on <b>12-18-56</b> Death occurred at <b>a.</b> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Harry K. Cohen</b> (Degree or title)				22b. ADDRESS <b>318 Regyle Bldg</b>		22c. DATE SIGNED <b>12-19-56</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-19-56</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sheffield</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>		
24. FUNERAL DIRECTOR <b>Louis Funl Home</b>			ADDRESS <b>K.C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-20-56</b>		26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

Health, Welfare, Public Service  
300  
1-56  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Harry K. Cohen

MEDICAL CERTIFICATION

7/10-1-4226

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 *Gray Kuffington*  
Licensed Embalmer No. 27

P. O. Address *H. O. 7*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.