MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

17319

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. 2292

Township Kaw — Primary Registration District No. 1002 — Registered No.

City Kansas City (No. K.C. General Hosp. St. Ward)

2. FULL NAME Schaeffer James

(a) Residence. No. 2439 Olive St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 4, 1860

7. AGE: Years 67 — Months 11 — Days 19 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Higginsville, Mo

PARENTS

10. NAME OF FATHER: James H. Schaeffer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Scotland
12. MAIDEN NAME OF MOTHER: Mary Ann Woods
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Lexington, Ky

14. INFORMANT: Mr W. E. Wilmott
(Address) 2439 Olive

15. FILED 5/24, 1928 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-23 1928

17. I HEREBY CERTIFY, That I attended deceased from 5-20, 1928 to 5-23, 1928 that I last saw him alive on 5-23, 1928, and that death occurred, on the date stated above, at 11:08 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Findings

(Signed) P. E. Williams, M.D.
5-24, 1928 (Address) Supt K. C. Genl Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Washington — DATE OF BURIAL: May 25 1928

20. UNDERTAKER: D.W. Newcomer & Son — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....

Township..... Primary Registration District No. 1002 Registered No. 2292

City K. City (No....., ... St. ..... Ward)

2. FULL NAME Schaffner James

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W	S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT.....
(Address)

15. FILED 5-24, 1928 M. M. Brown
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-23 1928

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS
	K C Mo

SUPPLEMENTARY

WRITE PLAINLY WITH INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be stated. AGE should be stated in YEARS. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT ISSUE CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW, A FEE ...

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