

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

Do not use this space.

8810

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 3128 Oak St.)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1188
St. _____ Ward)

2. FULL NAME

George Paul Scharff
(a) Residence, No. 3128 Oak St. St. 5 Ward.

(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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>May Helmer Scharff</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>6-16-1838</u>		
7. AGE	YEARS	MONTHS
	<u>91</u>	<u>8</u>
		DAYS
		<u>29</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Retired</u> (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) Germany

10. NAME OF FATHER Andrew Scharff

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Mrs. J. F. Bowman
(Address) 3126 Oak St.

15. FILED 3/17/30 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 15 1930

17. I HEREBY CERTIFY, That I attended deceased from about Jan 1st, 1930, to Mar 15, 1930
that I last saw him alive on Mar 12, 1930, and that death occurred, on the date stated above, at 11:45 P.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral hemorrhage
82 P. (left side)
97 few hours
(duration) yrs. mos. ds.
CONTRIBUTORY Arteriosclerosis
(SECONDARY) (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? physical
(Signed) E. H. Feilinger, M. D.
3/16, 1930 (Address) P. C. Box

*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 Logansport Ind. DATE OF BURIAL 3/18 1930
UNDERTAKER Stine & McClure ADDRESS City Mo

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.

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RECORD THIS IS PERMANENT RECORD

Dr. E. H. Zeilinger
226 Hyde Park West, Lo 0790
5036 Brookside.

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