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.

REC'D APR 17 1939

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

9664
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson 1
(b) Township Kaw 1
(c) City K. C. Mo.
Registration District No. 399
Primary Registration District No. 1002
Registered No. 1270
(d) Street No. Trinity Lutheran St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 863 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs. Bertha J. Schickhardt
(a) Residence, No. 5616 Bales St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Gus L. Schickhardt
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 26, 1881
7. AGE: Years 57 | Months 5 | Days 25 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Mo.

FATHER
13. NAME Daniel Gille 6
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 6

MOTHER
15. MAIDEN NAME Marie Beyer 6
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Gus L. Schickhardt
(ADDRESS) 5616 Bales

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Moriah DATE Mar. 24, 1939

19. FUNERAL DIRECTOR (NAME) John W. Wagner
(ADDRESS) Kansas City, Mo.

20. FILED Mar 23 1939 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 21, 1939

22. I HEREBY CERTIFY, That I attended deceased from 3 21, 1939, to 3 21, 1939
I last saw h. alive on 3 21, 1939. Death is said to have occurred on the date stated above, at 8:40 m. pm
The principal cause of death and related causes of importance were as follows:

Date of onset

Cerebral Hemorrhage
Arteriosclerosis
Death in 3½ hrs

Other contributory causes of importance: 131

Chronic Hypertension
Chronic Nephritis

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify 1
(Signed) C. C. [illegible], M. D.
(Address) Prop Bldg

(Licensed Embalmer's Statement on Reverse Side)

Dr. G. C. Conover,
Prof. Bldg.,
VI 2443

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED, BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.