

REC'D APR 17 1930

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

9730  
Do not use this space.

1. PLACE OF DEATH  
(a) County Jackson Registration District No. 399  
(b) Township Kaw Primary Registration District No. 1002  
(c) City K. C. Mo. (d) Street No. 3033 Grand Registered No. 1336 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 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Joseph L. Schutty  
(a) Residence, No. 3033 Grand St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 10, 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>81</u>	<u>8</u>	<u>16</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	<u>Retired</u>
9. Industry or business in which work was done, as saw mill, bank, etc.	<u>Carpenter</u>
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) Fort Madison, Wis.

FATHER

13. NAME Joseph Schutty

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER

15. MAIDEN NAME Katherine Smith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) France

17. INFORMANT (ADDRESS) Clarence A. Schutty  
4610 E. 7th St. K.C. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. St. Mary's DATE Mar. 28, 1930

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John W. Wagner  
K. C. Mo.

20. FILED Nov 27, 1939 M. M. Brown  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 26, 1939

22. I HEREBY CERTIFY That I attended deceased from 19, 1939.  
I last saw deceased of deceased Death is said to have occurred on the date stated above, at 10:30 P.M.  
The principal cause of death and related causes of importance were as follows:  
Coronary occlusion  
Chronic diffuse myocardial fibrosis  
Acute pulmonary edema & congestion

Other contributory causes of importance:  
None

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

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 \_\_\_\_\_  
(Signed) Arthur H. Hubler M. D.  
(Address) San Diego, K.C. 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.

**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 comply with the above constitutes grounds for revocation of license.)**

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