

REC'D MAY 10 1939

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

14044

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 395  
(b) Township 1st Primary Registration District No. 9102 Registered No. 1798  
(c) City Kansas City (d) Street No. Memorial Hospital (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
(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

William J. Scharles  
(a) Residence, No. 420 E. Prussar Blvd. 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 <u>Male</u>	4. COLOR OR RACE <u>Wh</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Polly Scharles</u>			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 14 - 1876</u>			
7. AGE YEARS <u>72</u>	MONTHS <u>8</u>	DAYS <u>14</u>	If LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION		8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Salvage</u>	
		9. Industry or business in which work was done, as saw mill, bank, etc. <u>Insurance</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) <u>New York City New York</u>			
FATHER			
13. NAME <u>Herman Scharles</u>			
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Hungary</u>			
MOTHER			
15. MAIDEN NAME <u>Hannie Newman</u>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Hungary</u>			
17. INFORMANT (ADDRESS) <u>Dr. Frederick Scharles 420 E. Prussar Blvd.</u>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Fun Concerns</u> DATE <u>4/30</u> 19 <u>39</u>			
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Cerrall Ferguson 3824 Trost</u>			
20. FILED <u>Apr 30</u> 19 <u>39</u> <u>M. M. Brown</u> Local Registrar.			

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 28 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1932 to Apr 28 1939  
I last saw him alive on Apr 28 1939 Death is said to have occurred on the date stated above, at ..... m.  
The principal cause of death and related causes of importance were as follows:  
Arterio-sclerosis - Date of onset  
Chronic Myocarditis - few years  
Pyelo-nephritis - a few months

Other contributory causes of importance: 93c

Name of operation Cystostomy Date of Nov/39  
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) A. Sophieau M. D.  
(Address) 1405 Bryant Bldg

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**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.**