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 JUN 8 1939

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

Do not use this space. 17610

1. PLACE OF DEATH
(a) County Jackson 1 Registration District No. 399
(b) Township Kaw 2 Primary Registration District No. 1002 Registered No. 2012
(c) City Kansas City (d) Street No. St Joseph's Hospital 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 John Scheibmeir
(a) Residence, No. 156 Iola Kans 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 male
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 Katherine Scheibmeir
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-25-1855
7. AGE YEARS 83 MONTHS 4 DAYS 17 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Retired
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) Germany

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

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

17. INFORMANT (ADDRESS) Leo Scheibmeir 3028 Wabash K.C. Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Iola Kans. DATE 5/15 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stine & McClure U. Co. K.C. Mo.
20. FILED May 14, 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/12 1939
22. I HEREBY CERTIFY, That I attended deceased from May 11, 1939, to May 12, 1939
I last saw him alive on May 11, 1939. Death is said to have occurred on the date stated above, at 3 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Thrombosis	1 day
82 B	
Other contributory causes of importance: Arteriosclerosis	Years

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

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? St Jos Hosp (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) Dr John A Kramer M. D.
(Address) 1402 Bryant N.C.

(Licensed Embalmer's Statement on Reverse Side)

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.