

Registration District No. **399**

Primary Registration District No. **1802**

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Kansas City**  
(c) Name of hospital or institution **St. Joseph Hosp**  
(d) Length of stay: In hospital or institution **6 wks**  
In this community **6 wks**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Wyandotte**  
(c) City or town **Kansas City**  
(d) Street No: **915 Osville**  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME **Schuetz, John**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **510-05-2901**

4. Sex **Male** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Millie Schuetz**

6. (c) Age of husband or wife if alive **35** years

7. Birth date of deceased **November 10, 1902**

8. AGE: Years **37** Months **0** Days **1** If less than one day hr. min.

9. Birthplace **Papico Kansas**

10. Usual occupation **Bricklayer**

11. Industry or business

12. Name **Conrad Schuetz**

13. Birthplace **Germany**

14. Maiden name **Elizabeth**

15. Birthplace **Germany**

16. (a) Informant's own signature **Millie Schuetz**

(b) Address **915 Osville Ave**

17. (a) **Buried** (b) Date thereof **Nov 13, 1939**

(c) Place: burial or cremation **mt. Calvary**

18. (a) Signature of funeral director **W. M. Brown**

(b) Address **322 No 7th Kansas City, Mo**

19. (a) **Nov 17 39** (b) **W. M. Brown**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **18** - **39** year hour minute **5 P** M.

21. I hereby certify that I attended the deceased from **10-15-39** to **11-11-39** that I last saw him alive on **11-11-39** and that death occurred on the date and hour stated above.

Immediate cause of death **Endocard Failure & Pulmonary Edema**  
Due to **Cholemia**  
Due to **Obstruction of the Common Bile Duct & Liver & Retro Peritoneal Metastasis**  
Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **None**  
Of autopsy **None**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (e) Means of injury **1**  
23. Signature **W. M. Brown** (M. D. or other)  
Address **322 No 7th** Date signed

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39 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 *F. A. Keisinger*

Licensed Embalmer No. 3122

P. O. Address 322 1/2 W. 5th St

**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.

Kansas City, Mo.