

JAN 13 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4951

1. PLACE OF DEATH:

(a) County Jackson Co. Mo.
 (b) City or town Kansas City Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Joseph 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 da. (Specify whether)

In this community 2/6/39
 years, months or days

3. (a) PRINT FULL NAME Paul Eugene Schuer

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased July 13 - 1931
 (Month) (Day) (Year)

8. AGE: Years 8 Months 5 Days 17 If less than one day hr. min.

9. Birthplace Pleasant Hill Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

12. Name Flloyd O. Schuer

13. Birthplace Smithfield Illinois
 (City, town, or county) (State or foreign country)

14. Maiden name Myrtle Bennett

15. Birthplace Seneca Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Flloyd O. Schuer

(b) Address Pleasant Hill Mo.

17. (a) Removal (b) Date thereof Jan 7 - 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Hill Mo.

18. (a) Signature of funeral director H. J. Hoffmeyer

(b) Address Pleasant Hill Mo.

19. (a) Dec. 31, 1939 (b) M. M. Crowe
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass
 (c) City or town Pleasant Hill Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 30th
 year 1939 hour 1 minute 10 P. M.

21. I hereby certify that I attended the deceased from Dec. 28, 1939 to Dec. 30, 1939
 that I last saw him alive on Dec. 30, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Shock
 Due to Pulmonary embolism

Due to osteotomy of femur tumor with bone transplant

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations Giant cell tumor left femur upper third
 Of autopsy See autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature H. Lewis Hess (M. D. or other)

Address 1007 Kialto Bldg. Date signed 1/2/40

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.

2-38511-1-38 MISSOURI STATE BOARD OF HEALTH—STANDARD CERTIFICATE OF DEATH—1939

3554

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.....

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

Signed.....

A. A. Hofmeyer
Licensed Embalmer No. 3928

P. O. Address Pleasant Hill, S

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

H2547
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No.
(b) Township Primary Registration District No. Registered No. 4951
(c) City (d) Street No. *St. Joe Hoops* 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

(a) Residence, No. *Paul Eugene Schuess* 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 *wh.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

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

7. AGE 8 YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

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.

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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED *12/31/39* *M. M. Brown*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 30*, 19*39*

22. I HEREBY CERTIFY, That I attended deceased from to 19.....

I last saw h..... alive on 19..... 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:

Stroke
Pulmonary Embolism
Resection of bow
tumor - Brod malignant
with bone transplants
Other contributory causes of importance:
Seam cell tumor left femur upper third.

Date of onset *154*

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

(Signed) M. D.

(Address)

SUPPLEMENT

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

42542
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No. 4951
(c) City..... (d) Street No. St. Joseph Mo. 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

(a) Residence, No. Paul Eugene Schuess 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 Wh
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

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

7. AGE 8 YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.

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.....

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 12/31 1929 J. M. M. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 30 1939

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on 19..... 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:

Stroke - Pulmonary embolism
54

Other contributory causes of importance:

Brain cell tumor of femur of nonmalignant

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.....

(Signed)....., M. D.

(Address).....

SUPPLEMENT

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.