

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **24203**  
Registrar's No. **2813**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 28 Days  
(Specify whether years, months or days) 28 Days

3. (a) PRINT FULL NAME Mr. John G. H. Schepmann

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Anna A. Schepmann 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased November 19, 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 7 23 hr. min.

9. Birthplace Holland Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Retired

12. Name Herman F. Schepmann

13. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Louise Dubber

15. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Earl Schepmann

(b) Address Box 126 Holyrood, Kans.

17. (a) Removal (b) Date thereof July 12, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Holyrood, Kansas

18. (a) Signature of funeral director W. M. McManis Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) July 12, 1940 (b) M. M. Browne  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Ellsworth  
(c) City or town Holyrood  
(If outside city or town limits, write "RURAL")  
(d) Street No. Near Holyrood  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12  
year 1940 hour 10 minute 50A M. M.

21. I hereby certify that I attended the deceased from June 15, 1940, to July 12, 1940;  
that I last saw him alive on July 11, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis  
Diabetes

Due to 51

Due to \_\_\_\_\_

Other conditions Carcinoma Prostate  
(Include pregnancy within 3 months of death)

Major findings: Bilateral vasectomy

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_  
(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)  
(e) Means of injury !

23. Signature W. M. McManis Sons (M. D. or other)

Address 500 Professional Bldg Date signed 7-2-40

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

MOTHER FATHER

W. C. Smith  
505. P. R. F. 13h  
all 4.

**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..... *Emile M. Calhoun*.....  
Licensed Embalmer No..... *3506*.....  
P. O. Address..... *F. C. Mo*.....

**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.**