

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24270
Registrar's No. 2880

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. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days) Infant Schmidt

3. (a) PRINT FULL NAME Baby girl Schmidt 530

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

4. Sex Female 5. Color or race w 6. (a) Single, widowed, married, divorced Infant

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

7. Birth date of deceased July 12 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 55 min.

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

10. Usual occupation Infant

11. Industry or business Infant

12. Name Albert Harold Schmidt

13. Birthplace Jarkio Mo
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Jeffrey

15. Birthplace Topseka Kans
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Harold Schmidt
(b) Address 456 East 55th

17. (a) Cremation (b) Date thereof 7-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cremation - St. Luke's

18. (a) Signature of funeral director St. Luke's Hosp
(b) Address _____
19. (a) July 18, 1940 (b) M. D. Craue
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 456 East 55th
(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 3:50 minute A M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw her alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Extra-uterine asphyxia and asphyxiation

Due to Perforated Sep. Placenta

Due to Maternal Injuries

Other conditions: 159
(Include pregnancy, within 3 months of death)

Major findings: Concealed Uterine Hemorrhage of mother.
Of operations _____
Of autopsy: Partial congenital atelectasis

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) (a) Means of injury _____

23. Signature R. C. M. O. (M.D. or other) _____
Address R. C. M. O. Date signed 7/12/40

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.