

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:
317 So Topping
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days) 8 yrs

3. (a) PRINT FULL NAME William H. Schneider

3. (b) If veteran, name war no
3. (c) Social Security No. 709-12-04184

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Jane Schneider
6. (c) Age of husband or wife if alive W R years

7. Birth date of deceased 3 18 1898
(Month) (Day) (Year)

8. AGE: Years 42 Months 5 Days 21
If less than one day .hr. .min.

9. Birthplace Highwayville Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business B + O Railway

12. Name Henry F. Schneider

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

14. Maiden name Julia Klum

15. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Chas F. Schneider

(b) Address 911 Penn

17. (a) Burial (b) Date thereof 9-4-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highwayville Mo

18. (a) Signature of funeral director John P. Schell

(b) Address 6666 Independence

19. (a) Sept. 3, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 317 So Topping
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 24 year 1940 hour 12 minute 15 M.

21. I hereby certify that I saw the deceased from 12-15 1940 to 12-15 1940; that I personally saw the deceased alive on 12-15 1940 and that death occurred on the date and hour stated above.
Immediate cause of death Acute pulmonary edema
Acute myocardial infarction
Acute coronary occlusion
Other conditions Coronary sclerosis
(Include pregnancy within 3 months of death)
Major findings:
Of operations 94B
Of autopsy

PHYSICIAN

94B
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)
(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) (Specify type of injury) 5

23. Signature Walter W. Miller (M. D. or other)
Address K.C. Mo Date signed

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

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.....

Joe B. Yoder....., Registered Apprentice No. #233
working under my personal supervision.

Signed.....

J. Sheil
Licensed Embalmer No. 3625

P. O. Address K.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.