S. No. 2
-11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34559

NOV 12 1940

Registration District No. 1002

Primary Registration District No.

Registrar's No. 4075

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

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:
K.C.General Hospital No. 1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days (Specify whether
In this community Few Weeks
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 622 Garland
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME JOHN D. SCHOONOVER

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 divorced

6. (b) Name of husband or wife Lucy Schoonover

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

7. Birth date of deceased Sept.25,1872
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	0	27	hr. min.

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

10. Usual occupation laborer

11. Industry or business

FATHER
12. Name Roderick Schoonover
13. Birthplace Kirkwood, Ill.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Nellie Williamson
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant WilburSchoonover
(b) Address Rt.3 Parkville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct.25,1940
(Month) (Day) (Year)
(c) Place: burial or cremation Line Creek,Clay Co.,Mo.

18. (a) Signature of funeral director Morton Funeral Home
(b) Address North K.C.,Mo.

19. (a) 10-23-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22nd
year 1940 hour 10 minute 50 P. M.

21. I hereby certify that I attended the deceased from October 7th, 1940 to October 22nd, 1940;
that I last saw him alive on October 22nd,1940, 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bilateral lung abscess with empyema	
Due to Chronic myocardial fibrosis	
Due to Chronic passive congestion of liver	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of 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)
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Drury R. Thone (M. D. or other)
Address Med.Dir.K.C.Gen.Hospital, K.C.,Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Harold L. Posson

Licensed Embalmer No. 3605

P. O. Address North Kansas

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.

. No. 2B
—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. ?

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 4075

SUPPLEMENTARY

1. PLACE OF DEATH

(a) County Jackson

(b) City or town K.C. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ..... (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town ..... (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.

3. (a) PRINT FULL NAME John D. Schoonover

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife .....

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

7. Birth date of deceased ..... (Month) (Day) (Year)

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

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) 10/23/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. 22 - 40 day ..... year ..... hour ..... minute ..... M.

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

Immediate cause of death: Bilateral lung abscess c̄ empyema

Due to Chr. Myocardial fibrosis

Due to Chr. pass. cong. of liver

Other conditions ..... (Include pregnancy within 3 months of death) 108

Major findings:
Of operations .....
Of autopsy .....

Duration

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) .....

(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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....

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