

Registration District No. 299

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: North East Hospital  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 11 days  
(Specify whether 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. 10515 Norledge  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Robert Schneller

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

20. DATE OF DEATH: Month Jan day 29 year 1941 hour 5 minute A M.

21. I hereby certify that I attended the deceased from Jan 28, 1941 to Jan 29, 1941 that I last saw him alive on Jan 28, 1941 and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Jan 28 1941

6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased: Jan 28 1941  
(Month) (Day) (Year)

Immediate cause of death: Myocardial Insufficiency

Due to Premature Birth

Other conditions (Include pregnancy within 3 months of death) 1516

8. AGE: Years 0 Months 0 Days 0 If less than one day 11 hr. 0 min.

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

10. Usual occupation

11. Industry or business

12. Name Peter J. Schneller

13. Birthplace Northampton Michigan  
(City, town, or county) (State or foreign country)

14. Maiden name Mary E. Butkovich

15. Birthplace Chicago Illinois  
(City, town, or county) (State or foreign country)

Major findings: Of operations

Of autopsy

PHYSICIAN: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Peter G. Schneller

(b) Address 10515 Norledge

17. (a) Burial (b) Date thereof 1/29/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Independence Mo.

18. (a) Signature of funeral director George C. Carson

(b) Address Independence, Mo.

19. (a) Jan 30, 1941 (b) M. M. Crow  
(Date received local registrar) (Registrar's signature)

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? no.

(Specify type of place) While at work? (a) Means of injury 2

23. Signature Dr. Frank Clark (M. D. or other)

Address 4316 89th. N.E.M. Date signed 1-29-41

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

MOTHER FATHER

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**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, fact should be so stated above.**