

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

9519  
State File No. \_\_\_\_\_  
928  
Registrar's No. \_\_\_\_\_

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: 5717 Tracy /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 35 years years, months or days)

8. (a) PRINT FULL NAME Mrs. Bertha Schmitz

8. (b) If veteran, name war XX 8. (c) Social Security No. None

4. Sex Fe / 5. Color or race Wh / 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John Schmitz 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased December 9 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 2 24 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Gottlieb Frank. 13. Birthplace 4 Germany  
(City, town, or county) (State or foreign country)

14. Maiden name No Record

15. Birthplace 4 Germany  
(City, town, or county) (State or foreign country)

16. (a) informant John Schmitz  
(b) Address 5717 Tracy

17. (a) Burial (b) Date thereof Mar 6 - 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Washington Cem.

18. (a) Signature of funeral director J.W. Wagner  
(b) Address Kansas City, Mo.

19. (a) Mar 5 - 41 (b) M.M. Craue  
(Date received local registrar) (Registrar's signature)

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. 5717 Tracy  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? 50 years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 3  
year 1941 hour 10 40 P.M.

21. I hereby certify that I attended the deceased from February  
March 25, 1941, to March 3, 1941  
that I last saw he alive on March 3, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Tobac Pneumonia

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

Due to Influenza

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations None  
Of autopsy \_\_\_\_\_

Duration  
1/3  
3/3  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (M. D. or other)  
23. Signature Wagner (M. D. or other)  
Address Wagner - Bldg Date signed 3/4-41

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

18  
3  
2

11-8952  
M. R. H. C. M.

**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 A. R. Haunschuld

Licensed Embalmer No. 4159

P. O. Address Kansas City, 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.**