

FILED MAY 16 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **13363**

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1314

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 1 Mo. & 1 day  
(Specify whether years, months or days)  
 In this community 2 yrs

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. 2817 Norton  
(If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2nd  
 year 1941 hour 5 minute 10 P. M.

21. I hereby certify that I attended the deceased from March 1st 1941 to April 2nd 1941  
 that I last saw her alive on April 2nd 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death:  
Chronic myocardial fibrosis; right chronic fibrinous pleurisy, Senile emphysema

Duration

Due to 93 W  
 Due to 93 W  
 Other conditions:  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
 Of operations  
 Of autopsy see above

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) (If means of injury)  
0

23. Signature Dr. R. Howard (M. D. or other)  
 Address Med. Dir., K.C. Gen. Hospital Date signed 3-19-41

3. (a) PRINT FULL NAME BESSIE SNYDER (Anna Butler)

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

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

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

7. Birth date of deceased Oct 27, 1864  
(Month) (Day) (Year)

8. AGE: Years 76 Months 58 Days 5 If less than one day hr. min.

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

10. Usual occupation at home

MOTHER FATHER

11. Industry or business

12. Name John G. Schroer

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

14. Maiden name Minkner

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

16. (a) Informant Mrs. J. K. Kuchel  
 (b) Address 723 Hawthorne

17. (a) Burial (b) Date thereof 4-5-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hills

18. (a) Signature of funeral director Blackman  
 (b) Address K. C. Mo.  
 19. (a) Apr 19 41 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

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

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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.....

*H. D. Blackman*

Licensed Embalmer No. *3639*

P. O. Address.....  
*R. E. ...*

**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.**