

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Burns city
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2125 Troost 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution TWO YRS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2125 Troost (If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME CAROLINE Amanda SCHRAWYER

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color of race Wh 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Arthur Schrawyer 6. (c) Age of husband or wife if alive 14 years (Month) (Day) (Year)

7. Birth date of deceased Aug 14 1860 (Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days 20 If less than one day hr. min.

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

10. Usual occupation House Keeper

11. Industry or business

MOTHER FATHER { 12. Name unknown
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace vv 9 (City, town, or county) (State or foreign country)

16. (a) Informant Robert Schrawyer

(b) Address Centerville Mo.

17. (a) Burial (b) Date thereof April 11 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Centerville Mo

18. (a) Signature of funeral director Sweeney Phillips

(b) Address Warrensburg Mo

19. (a) 4-9-41 (b) M. M. Cronin (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8th year 1941 hour 8:20 minute 20 M.

21. I hereby certify that I attended the deceased from April 16 1939 to April 8 1941 and that I last saw her alive on April 8th 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Primary adenocarcinoma of breast - Generalized Carcinomatosis
Due to unknown 50

Due to None 50
Other conditions (include pregnancy within 3 months of death) None 50

Major findings: Of operations None
Of autopsy No

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? ✓

While at work? ✓ (Specify type of place) (c) Means of Injury 0

23. Signature A. Schrawyer (M. D. or other) 0
Address 1830 Vine St Date signed 4-9-41

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

8
3
8

48
8

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 _____

Earl Priest

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Earl Priest

Licensed Embalmer No. _____

3878

P. O. Address _____

Warrinsburg 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.