

Registration District No. 277

Primary Registration District No. 1002

Registrar's No. 2951

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K.C. General Hospital, No. 1
(d) Length of stay: In hospital or institution About 10 min.
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 712 West 12th
(e) Citizen of foreign country? (Yes or No) No

3. (a) PRINT FULL NAME

Schmitz infant

(b) If veteran name war

(c) Social Security No.

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced S O
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 27 1941 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. 1.0 min. amt

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

10. Usual occupation nurse

11. Industry or business

12. Name Sylvester Schmitz
13. Birthplace Worema Mo (City, town, or county) (State or foreign country)
14. Maiden name Evelyn Martin
15. Birthplace Worema Mo (City, town, or county) (State or foreign country)

16. (a) Informant Rena Clark
(b) Address K.C. Gen Hospital

17. (a) Burial (b) Date thereof 8-5-41 (Month) (Day) (Year)

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

19. (a) Date received local registrar 8/4/41 (b) Registrar's signature M. M. Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27th year 1941 hour 3 minute 45 P.M. M.

21. I hereby certify that I attended the deceased from 7-27-41 to 7-27-41
that I last saw him alive on 7-27-41 and that death occurred on the date and hour stated above.

Immediate cause of death: PREMATUREITY

Due to 159
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Of autopsy

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?

23. Signature M. M. Brown (M. D. or other) O
Address Med. Dir. K.C. Gen/Hospital Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

47808 B NW2

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.