

FILED OCT 13 1941

State File No. \_\_\_\_\_

Registration District No. 397

Primary Registration District No. 1002

Registrar's No. 3402

1. PLACE OF DEATH: Jackson  
 (a) County \_\_\_\_\_  
 (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 18 days  
(Specify whether years, months or days)  
 In this community 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:  
Missouri Jackson 49  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1319 Bales 7  
(If rural, give location)  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Everett Schwyhart  
 3. (b) If veteran, name war None. 3. (c) Social Security No. CQ# 486-26-6453.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Sept. day 9th  
 year 1941 hour 8 minute 15 A. M.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced, Widowed  
 6. (b) Name of husband or wife Maude M. Schwyhart  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased February 5th, 1887.  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8-22-41 19\_\_\_\_ to 9-9-41 19\_\_\_\_;  
 that I last saw him alive on 9-9-41 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<u>54</u>	<u>7</u>	<u>4</u>		hr. _____ min.

Immediate cause of death  
Hemoperitoneum following cholecystectomy and appendectomy  
 Due to Gall stones

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Western Ice & Storage Co.

Due to \_\_\_\_\_  
 Other conditions Atelectasis of lower lobes of both lungs; coronary sclerosis  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
 12. Name Marion C. Schwyhart  
 13. Birthplace Logan County Ohio  
(City, town, or county) (State or foreign country)  
 14. Maiden name Jane Bush  
 15. Birthplace Wisconsin  
(City, town, or county) (State or foreign country)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy See above

16. (a) Informant Mrs. Mary Evans.  
 (b) Address 1319 Bales Ave.  
 17. (a) Burial (b) Date thereof 9/11/41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Mt. Washington

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? \_\_\_\_\_

18. (a) Signature of funeral director Melody McGilley  
 (b) Address K. C. Mo.  
 19. (a) 9/11/41 (b) M. H. Crow  
(Date received local registrar) (Registrar's signature)

While at work \_\_\_\_\_  
(Specify type of place) (Means of injury)  
 23. Signature Wm. R. Thom (M. D. or other) \_\_\_\_\_  
 Address Med. Dir. K.C. Gen. Hospital 9-9-41  
Date signed

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

MOTHER FATHER

**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.**