

V. S. No. 2
SOM-5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 10 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 458

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

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:
3716 Wyandotte
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

In this community 2 Months

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. 3716 Wyandotte
(If rural, give location)

(e) Citizen of foreign country?.....
(Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Opal R. Schulte

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Leo A. Schulte

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased October 5 1900
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>42</u>	<u>3</u>	<u>20</u>hr.min.

9. Birthplace Ma. O
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

12. Name William Stewart

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

14. Maiden name Dorothy Ashton

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

16. (a) Informant Leo A. Schulte

(b) Address 3716 Wyandotte

17. (a) Burial (b) Date thereof 1 30 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys

18. (a) Signature of funeral director Quirk E. Shinn

(b) Address 20 West Linwood

19. (a) 1-28-43 (b) M. M. Brome
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27
year 1943 hour 3 minute 35pm

21. I hereby certify that I attended the deceased from.....
Pathologist, 19....., to....., 19.....;
that I last saw him alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death abdominal Hodgkins disease

Due to..... 44B

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy Abdominal Hodgkins disease

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)

(e) Means of injury.....

23. Signature Geo. Walker (M. D. or other).....
Address Univ. of Kan. Hospital Date signed 1/27/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.