7. S. No. 2
DM—9-4-41
5-17-3

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9281

MAILED APR 8 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1516

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: St. Mary's hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 6 wks. (Specify whether years, months or days) In this community: 8 years

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.: 4840 Harrison (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country: 0

3. (a) PRINT FULL NAME: Miss Louise Schott

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: Fe

5. Color or race: Wh

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

6. (b) Name of husband or wife: Mar. 26, 1875

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

7. Birth date of deceased: Mar. 26, 1875 (Month) (Day) (Year)

8. AGE: Years: 68 Months: 0 Days: 2 If less than one day: hr. min.

9. Birthplace: Davenport, Iowa (City, town, or county) (State or foreign country)

10. Usual occupation: Housekeeper

11. Industry or business:

FATHER 12. Name: Julius Schott

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

MOTHER 14. Maiden name: Anna Meinheardt

MOTHER 15. Birthplace: Davenport, Iowa (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Anna Drake

(b) Address: 4840 Harrison

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/30/43 (Month) (Day) (Year)

(c) Place: burial or cremation: Galvary Cemetery

18. (a) Signature of funeral director: Thos. E. Quirk

(b) Address: 4316 Troost

19. (a) 3-29-43 (Date received local registrar) (b) R. R. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: March day: 28 year: 1943 hour: 2 minute: 20 P. M.

21. I hereby certify that I attended the deceased from 2-25-43, 19..., to 3-28, 1943, that I last saw he alive on 3-27, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar pneumonitis

Due to: —

Due to: —

Other conditions (Include pregnancy within 3 months of death): Fracture of Left leg

Major findings: Of operations: —

Of autopsy: —

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): accident-123

(b) Date of occurrence: 2-23-43

(c) Where did injury occur? at home, Jackson Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? no (e) Means of injury:

23. Signature: J. J. Bourke (M. D. or other) 0

Address: 0 Date signed: 3-29-43

(Licensed Embalmer's Statement on Reverse Side)

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 Thomas E. Lirk

Licensed Embalmer No. 3775

P. O. Address R. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.