

No. 4  
4-23  
17-39  
X35697

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13402

State File No. \_\_\_\_\_  
Registrar's No. 1951

FILED MAY 6 1943  
Registration District No. 177

Primary Registration District No. 1002

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 3 Days  
In this community 22 yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3228 Independence  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LUDWIG SCHWINHORST  
3. (b) If veteran, name war no  
3. (c) Social Security No. 522-07-5652

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 4 day 23 year 43 hour 2:15 min PM  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or Face White 6. (a) Single, widowed, married. Divorced widow  
6. (b) Name of husband or wife Debra 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 2 1884  
(Month) (Day) (Year)

Immediate cause of death: Secondary and degenerative disease of brain, kidneys and bronchi  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) Diffuse edema of lungs

8. AGE: Years 58 Months 4 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation Brewery  
11. Industry or business \_\_\_\_\_  
12. Name Schwinhorst  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

MOTHER FATHER {  
16. (a) Informant Marjorie White  
(b) Address 501 W. 3rd St.  
17. (a) Burial (b) Date thereof 4-26-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park  
18. (a) Signature of funeral director Durb + Johnson Co.  
(b) Address 20 West Linwood  
19. (a) 4/25/43 (b) M. M. Crown  
(Date received local registrar) (Registrar's signature)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy see above  
22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident 123  
(b) Date of occurrence 4/16/43  
(c) Where did injury occur Jackson Co Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Brewery  
While at work? yes (Specify type of work) (e) Means of injury Accident  
23. Signature [Signature] (M. D. or other) Yes  
Address [Address]

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..... *Charles M. Quinn*

Licensed Embalmer No..... *3774*

P. O. Address..... *KC 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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13402

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1951

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 Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_  
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. 3228 Independent  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ludwig Schwinko

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased see 2  
(Month) (Day) (Year)

8. AGE: Years 58 Months 4 Days \_\_\_\_\_  
If less than one day, hr. min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 23  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_, 19\_\_\_\_

that I last saw him \_\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

