

FILED JUN 7 1943 1/49

State File No. _____
Registrar's No. 1837

Registration District No. _____

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: 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 5 Hrs. (Specify whether
In this community unknown years, months or days)

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. 309 Garfield
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Schaff

3. (b) If veteran, name war no record 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced no record

6. (b) Name of husband or wife no record 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased no record (Month) (Day) (Year)

8. AGE: Years 75 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace no record (City, town, or county) (State or foreign country)

10. Usual occupation no record

11. Industry or business _____

MOTHER FATHER { 12. Name no record
13. Birthplace no record (City, town, or county) (State or foreign country)
14. Maiden name no record
15. Birthplace no record (City, town, or county) (State or foreign country)

16. (a) Informant Record clerk

(b) Address K.C. General Hospital No. 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-43 (Month) (Day) (Year)

(c) Place: burial or cremation Depts. A

18. (a) Signature of funeral director Stan A. Johnson

(b) Address City

19. (a) 4-17-43 (Date received local registrar) (b) Dr. W. W. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10th year 1943 hour 7:00 P. M. minute _____ M.

21. I hereby certify that I attended the deceased from 4-10-43, 19 to 4-10-43, 19; that I last saw him alive on 4-10-43, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to chronic cystitis; pyelonephritis

Due to _____

Other conditions Coronary sclerosis with myocardial fibrosis
(Include pregnancy within 3 months of death)

Major findings: None
Of operations _____

Of autopsy None - See above

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) Means of injury _____

23. Signature Dr. W. W. Crow (M. D. or other) Med. Dir. K.C. Gen. Hospital
Address _____ Date signed _____

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

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

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.