

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 8 1943
149
Registration District No.

Primary Registration District No. 1002

Registrar's No. 2792

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:
Kansas City Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 4 Months
(Specify whether
In this community... 35 years
years, months or days)

3. (a) PRINT FULL NAME. Mrs Alma Schlettner
3. (b) If veteran, name war. XX
3. (c) Social Security No. None

4. Sex. Female 5. Color or race. W 6. (a) Single, widowed, married, divorced. Widowed
6. (b) Name of husband or wife. August Schlettner 6. (c) Age of husband or wife if alive. _____ years
7. Birth date of deceased. Oct 29 1860
(Month) (Day) (Year)

8. AGE: Years 82 Months 7 Days 20
If less than one day _____ hr. _____ min.

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

10. Usual occupation. At Home

11. Industry or business _____

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

16. (a) Informant. Mrs Herman Loewe

(b) Address. 1532 East 49 St Terrace

17. (a) Burial (b) Date thereof. 6-21-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Forest Hill

18. (a) Signature of funeral director. J. W. Wagner

(b) Address. Kansas City Mo.

19. (a) 6-21-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

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. 1532 East 49 St Terrace
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country. 1

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 19
year 1943 hour 5 minute 0 M.
21. I hereby certify that I attended the deceased from 3-6-43
to 6-19-43
that I last saw h. r. alive on 6-18-43
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Arteriosclerosis</u>	<u>97</u>
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)
(e) Means of injury _____
23. Signature. [Signature] (M. D. or other)
Address. [Address] Date signed 20-43

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..... *Cecil R. Matthes*

Licensed Embalmer No. *3807*

P. O. Address. *Kansas City, Miss*

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.