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M-2-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3743
Registrar's No. 4817

FILED DEC 3 1943
Registration District No. 199

Primary Registration District No. 1002

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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: 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 3 days
In this community 1 yr. (Specify whether 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. 1216 Broadway
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Keith Morris Schreiber

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race WN 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug. 29, 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 2 7 1/2 hr. min.

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

10. Usual occupation None

11. Industry or business _____

12. Name Hyman Schreiber

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

14. Maiden name Pearl Billings

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

16. (a) Informant Hyman Schreiber

(b) Address K. C. Mo

17. (a) Burial (b) Date thereof 11-14-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W.P. Louis Funeral Home

18. (a) Signature of funeral director Mr. Meriah Cear

(b) Address K. C. Mo

19. (a) 11-15-43 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 14th
year 1943 hour 4 minute 40 P.M.

21. I hereby certify that I attended the deceased from November 11th 1943 to November 14th 1943.
that I last saw him alive on November 14th, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza; Meningitis

Due to 33 1/2

Due to _____

Other conditions (Include pregnancy within 3 months of death)

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) _____

(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 Dwight R. Thom (M. D. or other) _____

Address Gen'l Hosp. Date signed 11-15-43

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.