

Registration District No. 149

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 3 mos. 21 days  
(Specify whether 40 yrs)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Alma Scholz

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widow  
6. (b) Name of husband or wife John Scholz 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 10 1870  
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Germany (City, town, or county) (State or foreign country) 4

10. Usual occupation at home

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

MOTHER FATHER { 12. Name don't know  
13. Birthplace Germany (City, town, or county) (State or foreign country) 4  
14. Maiden name don't know  
15. Birthplace Germany (City, town, or county) (State or foreign country) 4

16. (a) Informant Mrs. M. R. Williams  
(b) Address 7132 Walnut

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-44 (Month) (Day) (Year)

(c) Place: burial or cremation Burial, Greenlawn

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Mo.

19. (a) 3-20-44 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL") P  
(d) Street No. 2626 Tracy (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 19 year 1944 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from November 19 1943 to March 19 1944 that I last saw her alive on March 19 1944 and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral accident Duration \_\_\_\_\_

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

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

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

Major findings: Of operations \_\_\_\_\_

Of autopsy See above

**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 Med. Dis.  
23. Signature A. E. Washburn (M. D. or other) 3-20-44  
Address 221 M. Co. Date signed \_\_\_\_\_

**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 Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address Kansas City, 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.**