No. 2
—2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 26 1945

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1602

State File No. 1422

Registrar's No. 123

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:
Krestwoods Conv. Home 2700 Tracy 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 mo. 24 days (Specify whether
In this community 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Hickman Mills 3
(If outside city or town limits, write "RURAL")

(d) Street No. 4264 Bannister Road 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 10

3. (a) PRINT FULL NAME FRANK O. SCHWARZ

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Ma 0

5. Color or race Wh

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Dena SCHWARZ

6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased November (Month) 8 (Day) 1865 (Year)

8. AGE:

Years	Months	Days	If less than one day
79	1	28	hr. min.

9. Birthplace Bern (City, town, or county) 5 Switzerland (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER
12. Name Fred Schwarz
13. Birthplace (City, town, or county) 5 Switzerland (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace (City, town, or county) 5 Switzerland (State or foreign country)

16. (a) Informant Marie Schwarz
(b) Address 416 E. 41st

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director J. W. Wagner
(b) Address Kansas City, Mo.

19. (a) 1-9-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 6th year 1945 hour 3: minute 55 P M.

21. I hereby certify that I attended the deceased from 11-2, 1944, to Jan. 6, 1945; that I last saw him alive on Jan. 6, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of prostate — Duration 1 yr.

Due to

Due to 51 B

Other conditions (Include pregnancy within 3 months of death) Trans urethral prostatectomy

Major findings:
Of operations Carcinoma prostate
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature M. B. Ketron (M. D. or other)
Address 1103 Grand Date signed 1-8-45

(Licensed Embalmer's Statement on Reverse Side)

14 0986

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, M

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.