

FILED JAN 19 1945

Registration District No. **146** Primary Registration District No. **3026** Registrar's No. **344**

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

1. PLACE OF DEATH:
 (a) County **JACKSON**
 (b) City or town **INDEPENDENCE**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1425 N. OSAGE ST. (CONVALESCENT HOME)
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 MONTHS** **4**
(Specify whether years, months or days)
 In this community **40 YEARS**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **JACKSON** **48**
 (c) City or town **INDEPENDENCE Rural** **0**
(If outside city or town limits, write "RURAL")
 (d) Street No. **9409 E. 16TH ST** **0**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country **1**

3. (a) PRINT FULL NAME **FREDERICK A. SCHWEERS**
 (b) If veteran, name war **NO**
 (c) Social Security No. **490-09-0628**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **1** day **1**
 year **1945** hour **6** minute **00** **A** M.

4. Sex **MALE** **0**
5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **WIDOWER** **2**
6. (b) Name of husband or wife **FRANCES ELLEN SCHWEERS**
6. (c) Age of husband or wife if alive **XXXXX** years
7. Birth date of deceased **9** **1** **1874**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Feb. 8**
 1940, to **Jan 1, 1945**
 that I last saw him alive on **Dec 26, 1944**
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	70	4	0	hr. min.

Immediate cause of death **Bronchial pneumonia 5d.**
 Due to **Bronchial Asthma years**

9. Birthplace **BURLINGTON IOWA**
(City, town, or county) (State or foreign country)

Due to
 Other conditions
(Include pregnancy within 3 months of death)

10. Usual occupation **RETIRED.**
11. Industry or business **INDEP. ICE & CREAMRY CO.**

Major findings:
 Of operations
 Of autopsy

MOTHER FATHER
12. Name **WILLIAM O. SCHWEERS**
13. Birthplace **HANOVER GERMANY**
(City, town, or county) (State or foreign country)
14. Maiden name **JOHANNA KAIZ**
15. Birthplace **HOCHDORF GERMANY**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **C. A. DAVIS**
(b) Address **9409 E. 16TH ST**

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

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof **1-3-45**
(Month) (Day) (Year)
 (c) Place: burial or cremation **MOUND GROVE**
18. (a) Signature of funeral director *[Signature]*
 (b) Address **815 W. MAPLE AVE**
19. (a) 1-2-1945 (Date received local registrar) (b) *[Signature]* (Registrar's signature)

23. Signa *[Signature]* (M. D. or other)
 Address **Independence, MO** Date signed **1/2/45**

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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, ~~by~~.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Henry W. Stahl*
Licensed Embalmer No. *3181*
P. O. Address *Independence*

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.