

V. S. No. 2
 00M-5-43
 Rev. 5-17-39
 I X38871

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 48400
 Registrar's No. 1930

FILED MAY 15 1945
 749

Registration District No. _____ Primary Registration District No. 1002

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: General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution since 4-8-45
(Specify whether years, months or days)

In this community 10 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Fred H. Schmitz

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 0

5. Color or race white

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

6. (b) Name of husband or wife Norma

6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased April 15, 1894
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>0</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation retired

11. Industry or business

12. Name Joseph Schmitz

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

14. Maiden name Ann Murphy

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

16. (a) Informant Oscar Schmitz,

(b) Address Atchison, Kansas.

17. (a) removal
(Burial, cremation, or removal)

(b) Date thereof 4-30-45
(Month) (Day) (Year)

(c) Place: burial or cremation Atchison, Kansas.

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 5-1-45
(Date received local registrar)

(b) Gereldine Holmes
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson, 48

(c) City or town Kansas City,
(If outside city or town limits, write "RURAL")

(d) Street No. 2900 Harrison
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29
 year 1945 hour 8:50 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Concussion of brain

Duration _____

Due to _____

Due to _____

Other conditions 1 stroke
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
 Of operations _____

Of autopsy no history & inspection

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) accident

(b) Date of occurrence 4-4-45 or 48-45

(c) Where did injury occur? 29th Harrison Jackson, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
public place

While at work? no. (Specify type of place)

(e) Means of injury Fall

23. Signature Gereldine Holmes (M. D. or other) 3
 Address 1424 Piper Blvd Date signed 4-30-45

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 *E. M. Blair*.....

..... Licensed Embalmer No. *1848*.....

P. O. Address *T. C. 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.)

1400 If this body is not embalmed, fact should be so stated above.