

S. No. 2
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5-17-39
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FILED SEP 4 1946

State File No. _____

Registration District No. 146

Primary Registration District No. 5568

Registrar's No. 290

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural (Blue)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
37th + Blue Ridge Cut Off - 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 14 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Rural (Blue)
(If outside city or town limits, write "RURAL")
(d) Street No. 37th + Blue Ridge Cut Off
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Vera Lurie Schafer

(b) If veteran, name war no (c) Social Security No. 493-26-3573

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced married!

6. (b) Name of husband or wife Herbert M. Schafer
6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased Jan 6 1899
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
47 7 18 hr. min.

9. Birthplace La Porte Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Unknown Wively
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Leona Montgomery
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Herbert M. Schafer
(b) Address R.F.D #9, Kansas City, Mo.

17. (a) Burial (b) Date thereof Aug 26, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation At local Kelly Cemetery

18. (a) Signature of funeral director E. Clark Stagent
(b) Address Raytown, Mo.

19. (a) 8-30-46 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24th
year 1946 hour 12 minute 50 P.M.

21. I hereby certify that I attended the deceased from Dec. 1, 1945 to Aug 24, 1946
that I last saw her alive on Aug 24, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma, left breast, with bone metastasis Duration 9 mo.
Due to Fracture, left hip 4 mo.
Due to Fall while walking.

Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) (z) Means of injury _____
23. Signature John K. Baldwin (M. D. or other) MD
Address 1036 Argyle Kansas City Date signed 8/25/46

354

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

JAN 22 1948

RECEIVED

Jackson County Health Dept.

County File Number

Date Filed

SEP 20 1946

SEP 9 1946

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. Clark Hegent*

Licensed Embalmer No. *3983*

P. O. Address *Raytown, 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.

Registration District No. 146

Primary Registration District No. 5568

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Maui
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____
(If rural, give location)

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

3. (a) PRINT FULL NAME Vera L. Schafer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Jan 6
(Month) (Day) (Year)

8. AGE: Years 77 Months _____ Days _____
If less than one day: hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year 1946 Hour _____ minute _____ M.

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

Immediate cause of death: Carcinoma left breast with bone metastases

Due to: Fracture left hip

Due to: Fall while walking

Other conditions: _____
(Include pregnancy within 3 months of death)

Duration

9 mo.

9 mos.

Major findings: _____

Of operations: _____

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: Contributory only - Accident

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence: April 29, 1946

(c) Where did injury occur? 37 + Blue Ridge, K.C. Jack Co. Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place, walking, on road near home, while walking
(Specify type of place)

While at work? no (e) Means of injury: Accidental fall

23. Signature: John K. Caldwell (M. D. or other) _____

Address: 1036 Maple Blk, K.C. Mo Date signed: 9/19/46

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

SUPPLEMENTARY

96285

27446