S. No. 2
OM—5-43
v. 5-17-39
e I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 25 1946

State File No. 30357

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3842

1. PLACE OF DEATH:

(a) County Jackson County, Mo.

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

(c) Name of hospital or institution: St. Luke's Hospital - 44th Millcreek Pkwy
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Mrs. Lucille Mann

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Fe

5. Color or race W

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

6. (b) Name of husband or wife Clay Mann

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased May (Month) 3 (Day) 1899 (Year)

8. AGE:

Years	Months	Days	If less than one day
47	4	4	hr. min.

9. Birthplace Weston (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business Home

FATHER
12. Name Walter Schendler
13. Birthplace Weston (City, town, or county) Mo (State or foreign country) 0

MOTHER
14. Maiden name Anna Hunt
15. Birthplace Weston (City, town, or county) Mo (State or foreign country) 0

16. (a) Informant Mr Clay Mann
(b) Address Platte City Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-10-46 (Month) (Day) (Year)
(c) Place: burial or cremation Weston Mo

18. (a) Signature of funeral director J. P. Sheil
(b) Address K. C. Mo

19. (a) 9-9-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept day 7th year 1946 hour 11 minute 55 A.M.

21. I hereby certify that I attended the deceased from Sept Fifth, 1946, to Sept 7, 1946, that I last saw her alive on Sept 7th, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Gartie hemorrhage — Duration 3 days

Due to Cancer of stomach c metastases — 6 mo?

Due to

Other conditions (Include pregnancy within 3 months of death) 46b

Major findings:
Of operations

Of autopsy Same as 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? ✓
(Specify type of place)

While at work? ✓ (e) Means of injury

23. Signature R. Bohan MD (M. D. or other)

Address Elaza Mud Bldg K Cm Date signed 9/9/46

(Licensed Embalmer's Statement on Reverse Side)

FEB 19 1958

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.....J. P. Shiel.....

Licensed Embalmer No.....3625.....

P. O. Address.....K. 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.)

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