

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. _____

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 No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 1/2 hrs.** (Specify whether
In this community **about 4 months**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **217 Admiral**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Lewis Schwager

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **M** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **single**

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

7. Birth date of deceased **Dec 12 1883**
(Month) (Day) (Year)

8. AGE: Years **63** Months **7** Days **18** If less than one day hr. _____ min. _____

9. Birthplace **Emporia Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farm Labor**

11. Industry or business _____

12. Name **Charles Schwager**

13. Birthplace **not known same**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown Schwager**

15. Birthplace **not known**
(City, town, or county) (State or foreign country)

16. (a) Informant **Della Schwager**

(b) Address **Emporia Kans**

17. (a) **Removal** (b) Date thereof **7-30-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Emporia, Kansas**

18. (a) Signature of funeral director **Weilert Funeral Home**

(b) Address **Kansas City, Missouri**

19. (a) **8-1-47** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30**
year **1947** hour **10** minute **45 P.** M.

21. I hereby certify that I attended the deceased from **July 29** 19**47**, to **July 30** 19**47**;
that I last saw him alive on **July 30** 19**47**;
and that death occurred on the date and hour stated above.

Immediate cause of death **CVA and pneumonia**
Bronchial

Due to _____

Due to _____

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

Major findings: Of operations **834**
Of autopsy **none**

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) (e) Means of injury _____

23. Signature **W. W. Hart** (M. D. or other) **MD**
Address **Med. Dir. Gen'l Hosp.** Date signed _____

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

MOTHER FATHER

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..... *Blaine E. Weibert*
Licensed Embalmer No..... *4075*
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.