S. No. 2
M—1/47
v. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 24 1947

Registration District No. 149

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 38412

Registrar's No. 4742

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 16½ hrs. (Specify whether
In this community unknown.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 9 x Central Muslim Hotel
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME John Edward Schneider

3. (b) If veteran, name war no

3. (c) Social Security No. unknown.

4. Sex Male 0

5. Color or race wh

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased unknown. (Month) (Day) (Year)

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Kansas (City, town, or county) (State or foreign country) 1

10. Usual occupation Cook

11. Industry or business

FATHER
12. Name Michael Schneider 5
13. Birthplace France (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Josephine McCoelty
15. Birthplace Illinois (City, town, or county) (State or foreign country) 1

16. (a) Informant Mathew Schneider
(b) Address Muskogee Okla

17. (a) Burlington Kans (Burial, cremation, or removal) (b) Date thereof 11/13/47 (Month) (Day) (Year)
(c) Place: burial or cremation Burlington Kans

18. (a) Signature of funeral director Sebbets Funeral Home
(b) Address K. C. Mo.

19. (a) 11-13-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12
year 1947 hour 3 minute 17 A. M.

21. I hereby certify that I attended the deceased from Nov. 11, 1947, to Nov. 12, 1947; that I last saw him alive on Nov. 12, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral vascular accident	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 830	
Major findings: Of operations	
Of autopsy None	

PHYSICIAN

Underline the cause of 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 0

23. Signature Wm W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 11-12-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Dr. Cushner

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 Ray E. Snow

Licensed Embalmer No. 2060

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.