

FILED NOV 24 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4786

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

(d) Length of stay: In hospital or institution 20 Days
(Specify whether _____)

In this community 15 Years
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. 7108 Jefferson Street
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME MRS. MYRTLE E. SCHUEPPENER

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Dewey D. Schueppener

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased February 8th 1893
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>54</u>	<u>9</u>	<u>7</u>	_____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name A. E. Patterson

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

14. Maiden name Lillian Rogers

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

16. (a) Informant Mr. Dewey Schueppener

(b) Address 7108 Jefferson Street

17. (a) Removal (b) Date thereof 11-16-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Platteville, Wisconsin

18. (a) Signature of funeral director Freeman Mortuary & Chapel

(b) Address 104 West 42nd, St. Kansas City, Mo.

19. (a) 11-15-47 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 15th.
year 1947 hour 2 minute 15 A.M.

21. I hereby certify that I attended the deceased from Oct. 26 1947, to Nov. 15 1947, that I last saw h.s. alive on Nov. 14 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Hypertension and Probable cerebral arteriosclerosis

Due to sepsis

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

Major findings: _____

Of operations: _____

Of autopsy: _____

Duration 19 days

2 yrs +

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)

23. Signature [Signature] (M. D. or other) MD

Address 836 Prof Bldg Date signed 11/15/47

WRITE PLAINLY—USING 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 Elmer C. Redelino

Licensed Embalmer No. 3495-

P. O. Address K. O. - 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.

University of Missouri

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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:
(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

3. (a) PRINT FULL NAME Myrtle E. Schuffener

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

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

8. AGE: Years _____ 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 _____

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 Mr. Dewey D. Schuffener

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11-15-47 (b) Theraldine Holmes
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day _____ year 1947 hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

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

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:

(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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

