

FILED AUG 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27046

State File No. _____

3339

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3339</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City, mo</u>		c. LENGTH OF STAY (in this place) <u>14 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Garden City, Mo.</u>		d. STREET ADDRESS (If rural, give location) <u>X 1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Joseph Hospital</u>				3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>E.</u> c. (Last) <u>Schrock</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Sept. 30, 1879</u>	
9. AGE (In years last birthday) <u>69</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 14 HRS. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Garden City mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Noah Schrock</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Plank</u>	
14. NAME OF HUSBAND OR WIFE <u>Synn Schrock</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>ms. Synn Schrock Garden City mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain Abscess Rt Parietal</u> (b) <u>Pneumonia Bronchocystic</u> (c) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchopneumonia</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>526</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
22a. SIGNATURE <u>Russell W. Kerr</u>				22b. ADDRESS <u>St Joseph Hospital</u>		22c. DATE SIGNED <u>8-2-49</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>8-4-49</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Garden City Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Garden City, mo.</u>	
DATE REC'D BY LOCAL REG. <u>8-2-49</u>		REGISTRAR'S SIGNATURE <u>Veraldine Holmes</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Atkinson Brothers</u>		ADDRESS <u>Garden City Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Howard Atkinson* _____

Licensed Embalmer No. *3920* _____

P. O. Address *Harrisonville* _____

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.

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