

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27103**
3517

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City | |
| c. LENGTH OF STAY (In this place) 16 yr. | | d. STREET ADDRESS (If rural, give location) 2918 Tracy | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 2918 Tracy (Katherine Hale Home) | | | |

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|---|---------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth b. (Middle) Ann c. (Last) Schmid | | | 4. DATE OF DEATH (Month) (Day) (Year) August 14, 1950 | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow | 8. DATE OF BIRTH May 21, 1865 | 9. AGE (In years last birthday) 85 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10b. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) Switzerland | |
| 13a. FATHER'S NAME Jacob Wenger | | | 13b. MOTHER'S MAIDEN NAME Elizabeth Utsenberger | | 14. NAME OF HUSBAND OR WIFE Julius G. Schmid |

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|--|--|-----------------------------------|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. H. T. Porter, 230 W. 62 Terr. K.C. Mo. | |
|--|--|-----------------------------------|--|--|--|

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|--|--|--|--|--|---|
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart failure from weakness of Sensitivity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) arteriosclerosis, essential DUE TO (c) arterial | | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks years 45 |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |

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|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.) | | 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 **June**, 19**46**, to **Aug 14**, 19**50**, that I last saw the deceased alive on **Aug 14**, 19**50**, and that death occurred at **9:05 p.m.**, from the causes and on the date stated above.

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|--|--|-----------------------------------|--|---|--|
| 23a. SIGNATURE Esther Winkelman (Degree or title) | | 23b. ADDRESS 4050 Broadway | | 23c. DATE SIGNED Aug 15, 50 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 24b. DATE 8-16-50 | | 24c. NAME OF CEMETERY OR CREMATORY - | |
| 24d. LOCATION (City, town, or county) (State) Sedalia, Missouri | | | | | |

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|---|--|---|--|---|--|
| DATE REC'D BY LOCAL REG. 8-16-50 | | REGISTRAR'S SIGNATURE Geraldine Holmes | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE UND. CO. KANSAS CITY, MO. | |
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(Licensed Embalmer's Statement on Reverse Side)

No. 300
10.48

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

Dr Esther Weiskelmann
4050 Broadway
Rm 4187

1:20 to 5:30 P.M.

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

Max C. Freyer

Licensed Embalmer No. *7555*

P. O. Address *Kansas City, 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.