

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41001**
5357

FILED JAN 5 1952

BIRTH NO. _____ REG. DIST. NO. **393** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a: STATE Missouri b. COUNTY Clay	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (in this place) 10 yrs		d. STREET ADDRESS (If rural, give location) 4823 45 Terr. N.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4823 45 Terr. N.			

3. NAME OF DECEASED (Type or Print)	a. (First) Adolph	b. (Middle) Christian	c. (Last) Schoettlin	4. DATE OF DEATH (Month) (Day) (Year) Dec 12 51
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2	8. DATE OF BIRTH 5 Dec 1892	9. AGE (In years last birthday) 79	if UNDER 1 YEAR Months 0 Days 7	if UNDER 24 HRS. Hours 1 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Greens keeper	10b. KIND OF BUSINESS OR INDUSTRY Golf Course	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Phillip Schoettlin	13b. MOTHER'S MAIDEN NAME Victoria Chwostek	14. NAME OF HUSBAND OR WIFE Sarah Ann Schoettlin
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. M.H. McFarren ADDRESS KC No.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH H500
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple Amputations			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12.12, 1951**, to **12.12, 1951**, that I last saw the deceased alive on **12.12, 1951**, and that death occurred at **11:48 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE E. J. Aikley, D.O. (Degree or title)	23b. ADDRESS 3917 N. Cleveland KC Mo	23c. DATE SIGNED 12.13.51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 15 Dec 1951	24c. NAME OF CEMETERY OR CREMATORY Maple Grove	24d. LOCATION (City, town, or county) (State) Trenton Mo.
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DATE REC'D BY LOCAL REG 12-13-51	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Mostern Funeral Home ADDRESS UKC
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WRITE PLAINLY—USING UNFADING 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

John M. ...

Licensed Embalmer No. *4854*

P. O. Address *St. Louis, 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.