

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6266

State File No.

796

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. LENGTH OF STAY (in this place) 6yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Campbell Nursing Home		d. STREET ADDRESS (If rural, give location) 255I Holmes St.	

3438

3. NAME OF DECEASED (Type or Print) a. (First) Lillian	b. (Middle)	c. (Last) Schenck	4. DATE OF DEATH (Month) (Day) (Year) Feb 6, 1953
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Aug. 18, 1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 84
11a. FATHER'S NAME Thomas Schenck		11b. MOTHER'S MAIDEN NAME No Record	11c. NAME OF HUSBAND OR WIFE Benj. F. Schenck
11d. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		11e. SOCIAL SECURITY NO. None	11f. INFORMANT'S SIGNATURE OR NAME Mrs. Ruby Lowrey
11g. ADDRESS 255I Holmes St.		11h. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.	
11i. CITIZEN OF WHAT COUNTRY? U. S.		11j. INTERVAL BETWEEN ONSET AND DEATH 3 Days	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis		DUPLICATE (b) Arteriosclerosis		3 Days
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE (c) Acute Bronchitis		3 mo.
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)				1 week.
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)	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 Feb. 2, 1953, to Feb 6, 1953, that I last saw the deceased alive on Feb. 5, 1953, and that death occurred at 3:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE John K. Caldwell (Degree or title)	23b. ADDRESS Kansas City, Mo.	23c. DATE SIGNED 2/6/53
24a. BURIAL CREMATION (Specify) Burial	24b. DATE Feb. 7, 1953	24c. NAME OF CEMETERY OR CREMATORY Rose Hill
24d. LOCATION (City, town, or county) Brookfield Mo.		(State)
DATE REC'D BY LOCAL REG. 2-6-53	REGISTRAR'S SIGNATURE Heraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Mrs. C. L. Forster
		ADDRESS Kansas City Mo.

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

Dr. J. K. Caldwell
Argyle Bldg.

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 *J. Sigil Herrick*

Licensed Embalmer No. *3589*

P. O. Address *A. 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.