

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18950

State File No. ....

2629

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u>				b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Mansas City</u>		c. LENGTH OF STAY (If this place) <u>48 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorah Med. Center</u>				STREET ADDRESS (If rural, give location) <u>704 W. H 6 Terrace</u>				<u>3610</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Josephine</u>			b. (Middle) _____			c. (Last) <u>Schoster</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6-17-55</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>4-21-1907</u>		9. AGE (In years last birthday) <u>48</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DENTAL TECHNICIAN</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>KANSAS CITY, MO.</u>		12. CITIZENRY OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>FRANK E. SCHOSTER</u>			13b. MOTHER'S MAIDEN NAME <u>CAROLINE SCHENK</u>			14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>489-30-3694</u>		17. INFORMANT'S SIGNATURE OR NAME <u>LOUIE C. SCHENK - GREENWOOD, MO.</u>			ADDRESS _____	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Cardiomyopathy due to</u> <u>norman quantity</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> <u>occipital neuralgia</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>None</u> Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH  <u>8954X</u>	
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) <u>123</u> 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 <u>1958</u> , to <u>June 17, 1955</u> , that I last saw the deceased alive on <u>June 17, 1955</u> , and that death occurred at <u>6:30 P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE OF <u>Dr. E. James Jr.</u> (Degree or title)				23b. ADDRESS <u>6306 Woodward Dr</u>		23c. DATE SIGNED <u>6/18/55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>6-20-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO.</u>				
DATE REC'D BY LOCAL REG. <u>6-20-55</u>		REGISTRAR'S SIGNATURE <u>Neve Marshall</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>FREEMAN MORTUARY</u>			ADDRESS <u>K.C. MO.</u>	

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

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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.....  
Signature of Student Embalmer

Signed *Walter H. Erwin*.....

Licensed Embalmer No. *43*.....

P. O. Address *Kansas*.....  
*Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.