

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29556

State File No.

FILED OCT 3 - 1955

BIRTH NO. _____ REG. DIST. NO. 133 PRIMARY REG. DIST. NO. 3022 Registrar's No. 84

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY OR TOWN <u>Bethany</u>		c. CITY OR TOWN <u>North Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>7 Mo.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Sullivan Rest Home</u>		e. STREET ADDRESS (If rural, give location) <u>816 E. 24th</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Elizabeth</u> b. (Middle) <u>Barbara</u> c. (Last) <u>Schanz</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9-30-55</u>		
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5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>10-1-1873</u>		9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>29</u>		IF UNDER 2 HRS. Hours <u></u> Min. <u></u>	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife retired</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u>			12. CITIZEN OF WHAT COUNTRY? <u>do not know</u>		
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13a. FATHER'S NAME <u>Martin Schmitt</u>		13b. MOTHER'S MAIDEN NAME <u>Julia (do not know)</u>		14. NAME OF HUSBAND OR WIFE <u>do not know</u>	
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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) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Rest Home Records</u>		ADDRESS	
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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						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic Pneumonia</u>		DUE TO (b) <u>Congestive Heart Failure</u>						<u>7 days</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) <u>Arteriosclerosis</u>						<u>see yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Severe Malnutrition</u>						<u>see yrs.</u>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4500</u>				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) (Minute)		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 May, 1955, to Sept, 1955, that I last saw the deceased alive on 9/1/55, 1955, and that death occurred at 9:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. Sutherland, M.D.</u>		23b. ADDRESS <u>Bethany, Mo</u>		23c. DATE SIGNED <u>10/1/55</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10-3-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Highland Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Kansas</u>	
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DATE REC'D BY LOCAL REG. <u>10/1/55</u>		REGISTRAR'S SIGNATURE <u>Zola Burrows</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. ...</u>		ADDRESS <u>Bethany Mo.</u>	
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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..... *MB Lass*

Licensed Embalmer No. *3899*

P. O. Address *Bethany, W*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.