

Health, Welfare Public Service

300 0-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

C.W. Mount

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4984

FILED FEB 27 1957

STATE FILE NUMBER
149 Primary Registration District No. 1002 Registrar's No. 520

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, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION 701 East Armour		Length of stay in lb 66 Years		d. STREET ADDRESS (If outside, give location) 701 East Armour	
3. NAME OF DECEASED (Type or print) First Mary Middle M. Last Schofield			4. DATE OF DEATH Month Feb Day 1 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1867	9. AGE (In years Birthday) 89	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (City and state or country) Olathe, Kansas	
13. FATHER'S NAME Henry Sheran			14. MOTHER'S MAIDEN NAME Kate Campbell		
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. None		17. INFORMANT Address Mrs. Thomas F. Fitzgerald 701 E. Armour	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-Intestinal Neurolysis due to Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Peptic ulcer DUE TO (c) Senility				INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 5400	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2		
20c. TIME OF INJURY Hour 10:00 Month Feb Day 1 Year 1957 P. M. P.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home		20f. CITY, TOWN, OR LOCATION COUNTY STATE Kansas City Jackson Mo	
21. I attended the deceased from Jan 15-1957 to Feb 1-1957 and last saw her alive on Jan 30-1957 . Death occurred at Home on the date stated above and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE C.W. Mount			22b. ADDRESS 5811 Humboldt		22c. DATE SIGNED Feb 1-1957
23a. BURIAL CREMATION REMOVE (Specify) Burial		23b. DATE Feb. 4, 1957		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
				23d. LOCATION (City, town, or county) (State) Kansas City Missouri	
24. FUNERAL DIRECTOR ADDRESS Melody McGilley Eylar Kan City, Mo.			25. DATE RECD. BY LOCAL REG. 2-2-57		26. REGISTRAR'S SIGNATURE Neva Marshall

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.....
Licensed Embalmer No. 29

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.